CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

KP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51028 — 17 2 E 51028

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 4 Ward)

2-FULL NAME Jas. A. Cordon

(a) **RESIDENCE** NO. N. Carolina St., Pittsboro (Chatham) Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Trav. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Marshall Field & Co

9 BIRTHPLACE (city or town) _____
(State or country) N. C.

PARENTS

10 NAME OF FATHER James A Cordon

11 BIRTHPLACE OF FATHER (city or town) N. C
(State or country)

12 MAIDEN NAME OF MOTHER Martha Telfair

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) N. C.

14 Informant Mrs Cordon
(Address) N. C.

15 Filed _____, 19__ C. HAMPSON JONES, M. D. Registrar
NOV 17 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by jumping from a window.

Dr. Frank Kluth and Internal Injuries (duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) _____

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? _____

(Signed) M. J. Kirby Coroner, M. D.

Nov 16 1929 (Address) 1639 Bryden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsboro - N. Carolina — DATE OF BURIAL Nov. 17 1929

20 UNDERTAKER W. A. Cook — ADDRESS 1212 N Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 51029

CERTIFICATE OF DEATH

90 E 51029
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N Glover ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H Le Compte

(a) RESIDENCE NO. 8 N Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a ~~Single~~, married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Joshua J. Le Compte

6 DATE OF BIRTH (month, day, and year) Oct 6/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Zachariah Trumer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Davis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Joseph J. Le Compte
(Address) 8 N Glover St

15 Filed ..... 19 C. HUMPHREYS JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14-29

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929 to Nov 14, 1929 that I last saw h[illegible] alive on Nov 13, 1929 and that death occurred, on the date stated above, at 11 50 A m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W White Jr. M. D.

11/15, 1929 (Address) 2803 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 17 1929

20 UNDERTAKER Mrs E. Miller & Son ADDRESS 2334 Jefferson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

NOV 17 1929

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51030

CERTIFICATE OF DEATH.

X 49 E 51030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (Ward) 9-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Adams.

(a) RESIDENCE No. Nort. George Meade Ave (Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: William G Adams

6 DATE OF BIRTH (month, day, and year): May 15. 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Carron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Katrina Carton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm G Adams

(Address) Nort George G Meade

15 Filed , 19 Nov 17 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Nov. 16, 1929, that I last saw h[illegible] alive on Nov 16, 1929, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? clinical

(Signed) J Robert Bardo M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Indianapolis Ind

DATE OF BURIAL 10/17 1929

UNDERTAKER: Wm Cook

ADDRESS 1217 St Paul

N. B.—WRITE PLAINLY, WITH INK, all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 17 1929 HARRY JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51031

CERTIFICATE OF DEATH

90 E 51031

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. ~~604~~ 407 E. Biddle St. 11-15 Ward)

2-FULL NAME Benedetto Lombardo

(a) RESIDENCE NO. 4079 Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: W. | 5 Single, Married, Widowed or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincenzo Lombardo

6 DATE OF BIRTH (month, day, and year) Dec 26, 1852

7 AGE: 76 Years | 10 Months | 20 Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS.

10 NAME OF FATHER G. ~~Unknown~~ Lombardo

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Constant Lombardo
(Address) 2809 Edmondson Ave

15 Filed ....., 19.... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 29 192

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. Dis. Heart

Dont Know (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

Where was disease contracted If not at place of death?

Did an operation preeede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Riley Coroner, M. D.

11-16 29 (Address) 1659 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral — DATE OF BURIAL: 11/19 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E. Pratt St.

NOV 17 1929

Spec.—8-16-29—L. P. S.—100 Blks.

Dr Sandrock Mrs Bell Nov 3363 Mrs 1403

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51032

CERTIFICATE OF DEATH

90 E 51032

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3920 Fernhill Ave ST. 27-63 WARD

2—FULL NAME Sarah C. Bellmeyer

(a) RESIDENCE NO. 3920 Fernhill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles E Bellmeyer

6 DATE OF BIRTH (month, day, and year) Dec 28. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph G. Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Morris

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs M Little

(Address) 3920 Fernhill Ave

15 Filed ..... 19 ..... H. HAMPSON JONES, M. D. Registrar

NOV 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14. 1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1929, to Nov. 14, 1929, that I last saw her alive on Nov. 14, 1929, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Cholecystitis (duration) 7 yrs. - mos. - ds.

(duration) 5 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar F. Sandrock, M. D.

19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 11/18 1929

20 UNDERTAKER Wellington Cook — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.--2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51033

CERTIFICATE OF DEATH

129 E 51033

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 203 S. Broadway ST. 9-4 WARD)

2—FULL NAME John H. Andrews

(a) RESIDENCE NO. 203 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Andrews

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Hugh Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary J. Gemmill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mary A. Andrews

(Address) 203 S. Broadway

15 Filed NOV 17 1929 By H. V. [illegible] Registrar

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16- 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10- 1928, to Nov. 16- 1929, that I last saw h- alive on Nov. 15- 1929 and that death occurred, on the date stated above, at 9 a- m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Incompetency

(duration) 2- yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) I Tenney Greene, M. D.

Nov 16, 1929 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov. 18 1929

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

Spec.—1-12-23—M&T—500 Blks.

E 51034

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51034

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 303 Gwynn Ave (ST.) 20-20 (WARD)

2-FULL NAME Telka Milosh

(a) RESIDENCE No. 303 Gwynn Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
58		—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mr. Velysis (Address) 303 Gwynn Ave

15 Filed NOV 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to Nov. 17, 1929, that I last saw h alive on Nov. 14, 1929 and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. J. Myers, M. D.

11-6, 1929 (Address) 5 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Stanclaus. DATE OF BURIAL 11/18 1929

20 UNDERTAKER Chas. B. Kuchauskas ADDRESS 637 S Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51035

92

E 51035

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Calvert Hall College Cathedral & Mulberry ST. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Casey

(a) RESIDENCE NO. Calvert Hall College ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) ----- 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 76	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Calvert Hall College

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Brother Gildas

(Address) Calvert Hall College

15 Filed 11 7 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15/29

17 I HEREBY CERTIFY, That I attended deceased from 11-15/1929, to Nov 15, 1929, that I last saw him alive on Nov. 15th, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) Morris A. Fine, M. D.

, 19 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/19 19 29
20 UNDERTAKER Henry W. Mears and Son	ADDRESS 805 N. Calvert

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51036

CERTIFICATE OF DEATH

90

E 51036

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1602 Eutaw Pl. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Addington

(a) RESIDENCE NO. 1602 Eutaw Pl ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. ? mos. ? ds. How long in U. S., if foreign birth? 85 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph C. Addington

6 DATE OF BIRTH (month, day, and year): About 1844

7 AGE: Years: About 85 | Months: — | Days: — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Mrs L. Biedler (friend)
(Address) 2101 Maryland Ave.

15 Filed NOV 17 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-15-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19 —, 1928, to Nov. 14 —, 1929, that I last saw him alive on Nov. 9 —, 1929, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mitral insufficiency.

unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis? X

(Signed) Elaine C. Pike, M. D.

11-16-1929 (Address) 1705 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Nov 18 29

20 UNDERTAKER: Thomas H Norris — ADDRESS: Balto.

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51037

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hampton Court Apts ST. D-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Estelle Fisher Robertson

(a) RESIDENCE NO. Hampton Court Apts ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 5 mos. 28 ds. How long in U. S., if foreign birth? 29 yrs. 5 mos. 28 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex. S. Robertson

6 DATE OF BIRTH (month, day, and year) May 19 50

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none MD

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. Fisher

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jane Boggs

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mrs Katherine R Hill-daughter
(Address) Ruxton Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1929

17 I HEREBY CERTIFY, That I attended deceased from August, 1929, to Nov 16, 1929, that I last saw h.. alive on Nov 16, 1929, and that death occurred, on the date stated above, at 10 25 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Mitral Insufficiency

(duration) 3 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
Aural Anaspaco
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Hall, M. D.

19 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Nov 18 1929

20 UNDERTAKER Stewart Memorial Chapel ADDRESS

OF DEATH in plain terms, so that it may be easily understood. important. See instructions on back of certificates.

NOV 17 1929 JAMES H. JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51038

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3502 Park Heights Av ST. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ysetta Goldberg

(a) RESIDENCE NO. 3502 P/H Hgts. Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rubin Goldberg

6 DATE OF BIRTH (month, day, and year): —

1859

7 AGE: Years 70 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Levin (Address) 1432 E Balto St.

15 Filed: Nov 18 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929 to Nov. 17, 1929 that I last saw h alive on Nov. 16, 1929 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

none. (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Nathan H Shpritz, M. D.

19 (Address) 2318 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sinai Memorial

DATE OF BURIAL: 11-17- 1929

20 UNDERTAKER: Jack Levin

ADDRESS: Jack Levin, 1432 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Every answer must be given. Unknown or a blank will cause delay. Please write plainly. All items are important. See instructions on back of certificates.

KOWITZ-THOMPSON-JONES, M.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51039

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51039

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert & 33rd ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Halton

(a) RESIDENCE NO. Glen Arm, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Long Green Md.

PARENTS

10 NAME OF FATHER Joseph C. Holton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Maryland

12 MAIDEN NAME OF MOTHER Margaret Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Maryland

14 Informant Hospital Records.
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 17, 1929, that I last saw h17 alive on Nov 17, 1929 and that death occurred, on the date stated above, at 8:10 a m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) Abt 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) Abt 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? Glen Arm, Md.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory & clinical findings

(Signed) William R. Fargo, M. D.

(Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns R C Cemetery — DATE OF BURIAL: 11/19 1929

20 UNDERTAKER: John E. Slade — ADDRESS: Long Green Md

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

NOV 1 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51040

CERTIFICATE OF DEATH

31

E 51040

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 166 Kossuth ST. (WARD) 20-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Estelle M. Stanton

(a) RESIDENCE NO. 166 Kossuth ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle J. Stanton

6 DATE OF BIRTH (month, day, and year) July 14, 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jim Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Estelle J. Stanton

(Address) 166 Kossuth

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 14, 1929

that I last saw h[illegible] alive on Nov 14, 1929

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (PHTHISIS)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) W. A. Kinnel, M. D.

11/N, 1929 (Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fair Lutherville	Nov 18 1929
20 UNDERTAKER	ADDRESS
J. R. Disput & Son	Baltimore

OF DEATH in plain terms, so that it may be understood. important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5104T

CERTIFICATE OF DEATH

124

E 5104T

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3722 Roland Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret L. Buell

(a) RESIDENCE NO. 3722 Roland Ave ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob A. Buell

6 DATE OF BIRTH (month, day, and year) Jan. 25-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George H. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Charles F. Palmer

(Address) 3722 Roland Ave.

15 Filed NOV 17 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15-1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1929, to November 15 1929, that I last saw her alive on November 15, 1929 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Sabine Carbuncle

Secondary infection of cervical glands.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Endocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Frank H. Mackey, M. D.

19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys Hampden	Nov. 18-1929.
20 UNDERTAKER	ADDRESS
Horace H. Burgee	3631 Falls Road

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51042

HEALTH DEPARTMENT—CITY OF BALTIMORE

1,001 ✓

CERTIFICATE OF DEATH

75 E 51042

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp ST. 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Wiesenbach

(a) RESIDENCE NO. 923 N. Patterson Pk ST., WARD
(Usual place of abode) Unknown
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chulley Hofferbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Eye

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record
(Address)

15 Filed ..... 19 .....
C. BAYARD JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-29

17 I HEREBY CERTIFY, That I attended deceased from 8-8, 19 29 to 11-15, 19 29

that I last saw h alive on 11-15, 19 29

and that death occurred, on the date stated above, at 5-9 a. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Right Partial Hemiplegia

(duration) Unknown yrs. mos. dy.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Balto City Hosp. M. D.

11-15, 19 29 (Address) Lab. Pumphrey

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 18 19 29
20 UNDERTAKER	ADDRESS
Frederick Lusby & Son	Fullerton

IMPORTANT. See instructions on back of certificates. FILL OUT CERTIFICATE OF DEATH in plain terms, so that it may be easily understood.

1923

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51043 90 E 51043

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 2202 Gough ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Dakota Hammett

(a) RESIDENCE NO. 2202 Gough ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~ Married, ~~Widowed, or Divorced~~, (write the word) Married

6a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Francis D. Hammett

6 DATE OF BIRTH (month, day, and year) Jan 14-1858

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jeremiah O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Francis D. Hammett
(Address) 2202 Gough St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Nov 14, 1929, that I last saw h[e] alive on Nov 13, 1929 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lowe, M. D.

11/14, 1929 (Address) 463 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 11/18, 1929

20 UNDERTAKER L. A. Moran

ADDRESS 2 Balto

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

ON FILE 1929 [illegible] NOS. FILED

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51044

CERTIFICATE OF DEATH

74001 L

E 51044

1—PLACE OF DEATH

REGISTERED NO. 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3105 Evergreen ave ST., WARD)

2—FULL NAME William J. Mackessy

(a) RESIDENCE NO. 3105 Evergreen ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary E. Mackessy

6 DATE OF BIRTH (month, day, and year): July 20-1879

7 AGE: Years 50 | Months 3 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer): Gen Publ.

(c) Name of employer: Co.

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: John Mackessy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mattie A. Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt

14 Informant: Mary E. Mackessy

(Address) 3105 Evergreen ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/17/29.

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to 11/17, 1929

that I last saw h— alive on 11/17, 1929

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Myles V. Foley M. D.

, 19 (Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Nov. 18, 1929

20 UNDERTAKER: John A. Moran

ADDRESS: 3000 E Balto St

OF DEATH in plain terms, so that it may be properly classified. All questions must be answered if possible, but those printed in italics are important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51045

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Clifton ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME L. Frank Crebs.

(a) RESIDENCE NO. 2017 Clifton ave ST., WARD Frederick Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. weeks. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Crebs

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carriage Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Not working at

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Louis Crebs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Mrs. Falconer

(Address) 1642 Indiana ave.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Nov 16, 1929, that I last saw h[illegible] alive on Nov 12, 1929, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

Brights Disease

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cannot state

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edwin Whelan, M. D.

, 19 (Address) 2129 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery Frederick

DATE OF BURIAL 11-19 1929

20 UNDERTAKER W. E. Falconer

ADDRESS Frederick Md.

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

V 1 1923 [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-002

E 51046

CERTIFICATE OF DEATH

E 51046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem. Hosp St. 26-41 Ward

2-FULL NAME Arthur Greer

(a) RESIDENCE NO. 4309 Sanna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Greer

6 DATE OF BIRTH (month, day, and year) July 4 - 1895

7 AGE: Years 34 | Months 4 | Days 12 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Mech.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER E. L. Greer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Butler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant Nancy Greer
(Address) 4309 Sanna St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Fract Femur C.C- auto which he was driving collided with car at intersection (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Alameda & Harford

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. J. Braun, M. D.

11/16 1929 (Address) 2939 W. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holland Harod Co — DATE OF BURIAL: 11/18 1929

20 UNDERTAKER: Chisom & Son — ADDRESS: 315 Cathedral Ave

N. B.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

230964 E S1047 — HEALTH DEPARTMENT—CITY OF BALTIMORE — X 133 E 51047 [redacted]

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. _____

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Murray

(a) RESIDENCE NO. Sparrows Pt Md ST., _____ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. mos. 17 ds. How long in U. S., If foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): $0.00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER: Robt. Murry

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: Liza Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Records (Address): JOHNS HOPKINS HOSPITAL

15 Filed _____, 19____ [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-17-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Nov 17, 1929, that I last saw him alive on Nov 17, 1929 and that death occurred, on the date stated above, at 1 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis. (33)

Pelvic Abscess. (53)

Obstruction Sigmoid with Ca of Colon (duration) yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Bot. Operature Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? Yes Date of 11-10-29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. D. Briggs, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morgantown W. Va	10/17/29
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

IMPORTANT. See instructions on back of certificates.

V 17 1929 C

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~E 51048~~ 100 ~~E 51048~~

CERTIFICATE OF DEATH

~~E 51048~~ REGISTERED NO. ~~E 51048~~

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Campbell

(a) RESIDENCE NO. 336 S. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Jane Campbell

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Hattie E. Brown

(Address) 336 S. Calhoun St.

15 Filed ..., 19 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1929, to Nov 15th, 1929.

That I last saw him alive on Nov 15th, 1929

and that death occurred, on the date stated above, at 6:00 A.m.

The CAUSE OF DEATH* was as follows: Bilateral Hydro-nephrosis - Hydro-Ureter with enduring Uraemia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (Bilateral) (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes — findings were those as above stated

What test confirmed diagnosis? Clinical & Laboratory

(Signed) W. B. Shapero M. D.

11-15, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Nov. 18, 1929

20 UNDERTAKER Harry N. Wittig 15-31W. — ADDRESS Lombard St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51049 ✓ 101-001

CERTIFICATE OF DEATH

E 51049

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3801 Edmondson Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Flynn

(a) RESIDENCE NO. 3801 Edmondson Ave (St.) (Ward)
(Usual place of abode)

Length of residence in city or town where death occurred 7y yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 18, 1904

7 AGE: Years 25 Months 6 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer): Store Keeper

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Thos. J. Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget McHale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Nell Flynn

(Address): 3801 Edmondson Ave

15 Filed NOV 1 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11.14.29.

17 I HEREBY CERTIFY, That I attended deceased from 11.10.29, 19 to 11.14, 19 29 that I last saw h[illegible]ive on 11.14, 19 29 and that death occurred, on the date stated above, at 6.45P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

acute nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

11.16.29. (Address) 107 East Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Nov. 18 19 29

20 UNDERTAKER: Margaret S. Flynn — ADDRESS: 1422 Eight St

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51050 — CERTIFICATE OF DEATH. — 90 — E 51050

REGISTERED NO. 1673

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Stockton St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Galloway

(a) RESIDENCE NO. 1025 Stockton ST. WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. / mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Charity Galloway

6 DATE OF BIRTH (month, day, and year) — — 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hauler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Wm Galloway (Address) 1218 East Lexington St.

15 Filed NOV 16 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 29th 29 to Nov 14. 1929, that I last saw him alive on Nov 14. 1929, and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

11/15, 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: Nov. 18, 1929

20 UNDERTAKER: Joseph A. Sively — ADDRESS: 419 N. Monroe St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51051 E 51051

161-001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital.

CITY OF BALTIMORE: (No. S. H-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Lyons

(a) RESIDENCE NO. 504 Murdock Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-11-'29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercy Hosp Baltimore Md

PARENTS

10 NAME OF FATHER Frank Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Amelia Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mercy Hospt

(Address)

15 Filed NOV 18 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1929, to Nov 17, 1929.

that I last saw him alive on 11-17, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature. (7 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Lyons, M. D.

11-17, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Groves	Nov 18 19 29
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Falls Rd

OF DEATH in plain terms, so that it may be understood. important. See instructions on back of certificates.

NOV 18 1929

Spec.—1-10-21—M&T—1500 Blks.

E 51052 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51052

CERTIFICATE OF DEATH.

11

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eden sts St. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Bell

(a) RESIDENCE No. 15-15 Clifton ave - ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mamie I Bell

6 DATE OF BIRTH (month, day, and year) Dec 21st 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	10	21 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania Railway Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Susie Blank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Mamie I Bell

(Address) 15 W Clifton Ave

15 Filed NOV 18 1929 C. HOWARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-31 1929 to 11-16 1929.

that I last saw him alive on 11-16 1929.

and that death occurred, on the date stated above, at 3.35 m.

The CAUSE OF DEATH* was as follows:

(Gangrenous appendix)

Ruptured Gangrenous appendicitis

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? While at work

Did an operation precede death? yes Date of 11-13-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M M Hundley, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Nov 19th 1929

20 UNDERTAKER John F. Cowan & Son

ADDRESS 901 Baltimore St.

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51053 90 E 51053

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 76-36

CITY OF BALTIMORE: (No.) 2746 Colgate Ave ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Bailey

(a) RESIDENCE NO. 2746 Colgate Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Bailey

6 DATE OF BIRTH (month, day, and year) Oct 16th 1872

7 AGE Years 57 Months — Days 24 *If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Gustave Leinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helena Viers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Bailey

(Address) 2746 Colgate Ave

15 Filed NOV 8 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1922, to Nov 11, 1929.

that I last saw her alive on Nov 10, 1929

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardio-Vascular disease

(duration) 27 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 27 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. McLearnine, M. D.

11/11, 1929 (Address) Dundalk, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 12th 1929

20 UNDERTAKER Ellsworth E. Fore — ADDRESS 1723 W. Lafayette Ave

DEATH CERTIFICATE Important. See instructions on back of certificates.

NOV 8 1929

Cor.—10-10-29—A Co.—100 Bks.

51054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 51054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1317 E. Monument St. 5-8 Ward)

2-FULL NAME Elizabeth Stewart

(a) RESIDENCE NO. 1317 E Monument St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15 / 29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel Stewart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Petersburg Va

12 MAIDEN NAME OF MOTHER Virgie Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Petersburg Va

14 Informant Virgie Stewart
(Address) 1317 E Monument

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 8 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

NOV 16 19

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make every OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

407

Spec.—2-29-28—L. F. S.—500 Bks.

230237
E 51055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 ✓ E 51055

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Patterson

(a) RESIDENCE NO. 890 Linden ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-15-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			26 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Clyde

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Ruth Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-11-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Nov 11, 1929, that I last saw her alive on Nov 11, 1929, and that death occurred, on the date stated above, at 1230 A m.

The CAUSE OF DEATH* was as follows:

Otitis media

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute gastroenteritis (duration) 7 days

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 3 ds. Johns Hopkins Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phy Exam

(Signed) J T Bickford Jr, M. D.

11/13/1929 (Address) 904

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 11 19

20 UNDERTAKER Commissioner Health, — ADDRESS

IMPORTANT. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

51056

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 51056

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1708 E. Preston ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas F. Hogan

(a) RESIDENCE NO. 1708 E Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Hogan

6 DATE OF BIRTH (month, day, and year) United States

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lieut. Detective

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Police Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Patrick Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Miss Ruth G. Hogan

(Address) 1708 E. Preston St.

15 Filed NOV 18 1929, C. HAMILTON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14th, 1929, to Nov. 15, 1929, that I last saw h[illegible] alive on Nov. 15, 1929 and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

11/16/1929 (Address) 1216 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 19 1929
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons, Inc.	1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51057

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51057

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH Balto. City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joshua Richardson

(a) RESIDENCE NO. 1425 E. Fairmount Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Howard Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sallie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of (Address): Baltimore City Hosp.

15 Filed NOV 16 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1929 to Nov. 16, 1929

that I last saw him alive on Nov. 16, 1929

and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Post. Mortem Autopsy

(Signed) Marvin M. McClean, M. D.

11-17, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Nov. 18 1929
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	Westminster Md

OF DEATH in plain terms, so that it may ... important. See instructions on back of certificates.

Spec. 12-9-25—A Co.—200 Bks. E 51058

HEALTH DEPARTMENT—CITY OF BALTIMORE

Remains must be stored on 11810 Mt Royal ave until 12/4/29

90 E 51058

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 11/23/29.

City of BALTIMORE: (No.) 121 W Mosher St. 11-24 (Ward)

2-FULL NAME Marcella A Shields

(a) RESIDENCE NO. 121 W Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of John Shields

6 DATE OF BIRTH (month, day, and year): Unknown 1861

7 AGE: Years: about 68. Months: Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Ireland.

PARENTS

10 NAME OF FATHER Charles Crickard

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland.

14 Informant: John Shields

(Address) 121 W Mosher

15 Filed NOV 26 1929 by C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/9/29, 19..., to 11/12/29, 19..., that I last saw h.. alive on 11/12/29, 19..., and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Myocarditis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W H Woodey, M. D.

19 (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Daw Patrick County Down Ireland

Date of Burial: 11/23 1929

20 UNDERTAKER: Charles F Evans & Son

ADDRESS 118 W Mt Royal ave

don should be carefully supplied. AGE should be stated EXACTLY. The Statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51059

CERTIFICATE OF DEATH

170 ✓

E 51059
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Lucy Hospital St. 26-37 Ward)

2-FULL NAME David J Griffith

(a) RESIDENCE NO. 6130 Garey St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Griffith

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tin Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Eastern Rolling Mill
(c) Name of employer

9 BIRTHPLACE (city or town) Wales
(State or country)

PARENTS

10 NAME OF FATHER Daniel Griffith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wales

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wales

14 Informant Cathy Jones
(Address) 605 Jefferson St

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:*

Suicide
Gun Shot Wound head
Revolver

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Stroke

(duration) yrs. mos. 3 hr ds.

18 Where was disease contracted — If not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What tests confirmed diagnosis? Phy Exam

(Signed) C C Ladell, M. D.
Nov 19 29 (Address) 1436 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 18 1929
20 UNDERTAKER	ADDRESS
Bus Co. Miller & Son	230 Jefferson

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OV 1 81929

Cor.—10-10-29—A Co.—100 Bks.

E 51060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 51060

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1805 E. Fairmount Ave St. 6-9 Ward)

2-FULL NAME Lillian M. Dorsey

(a) RESIDENCE NO. 1805 E. Fairmount Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. M. Dorsey

6 DATE OF BIRTH (month, day, and year): Feb 8/1858

7 AGE: Years 72 | Months 9 | Days 8 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country): Delaware

PARENTS

10 NAME OF FATHER: Capt. Robt. W. Cozier

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Delaware

12 MAIDEN NAME OF MOTHER: Sarah M. Jackson

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Balto., Md.

14 Informant: Benj. Butterworth
(Address): 1805 E. Fairmount Ave

15 Filed ..., 19.. HAMILTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 10/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility-

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos. H. Cowen, M. D.

1/18/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: Nov 13 1929

20 UNDERTAKER: Jos Pearsons Son

ADDRESS: 2073 E. Pr

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 10 1929

Spec.—1-10-21 M&T 1500 Blks.

E 51061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-002 E 51061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2302 Annapolis Rd. (St.) 25-37 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Chas. Patterson

(a) RESIDENCE No. 2302 Annapolis Rd. St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/15/05

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	24	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleswoman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Fleischman Co.

9 BIRTHPLACE (city or town) (State or country) Tarentum, Pa.

PARENTS

10 NAME OF FATHER Robert Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belfast, Ireland.

12 MAIDEN NAME OF MOTHER Rebecca Pickup

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harristown, Pa.

14 Informant Columbus Patterson (Address) 2302 Annapolis Rd.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1929, to 11/15, 1929, that I last saw h[illegible] alive on 11/15, 1929, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Para - typhoid B. infection

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Streptococcic endocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Lab. findings.

(Signed) J. W. Epstein M. D.

19 (Address) 2237 Annapolis Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem. DATE OF BURIAL Nov 18 1929

20 UNDERTAKER Jennie Sapper ADDRESS 1600 W North Ave

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa- TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51062 49 E 51062

CERTIFICATE OF DEATH

REGISTERED NO. 28-65

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2547 Hillsworth Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Jane Bryant

(a) RESIDENCE NO. 2547 Hillsworth Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Ranson T. Bryant

6 DATE OF BIRTH (month, day, and year) October 25, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	-	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Cole

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. William R. Bryant
(Address) Hillsdale, Md.

15 Filed NOV 18 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to Nov 17, 1929

that I last saw h or alive on Nov 17, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas and Enlarged Spleen

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Pancreas

(duration) yrs. 6 mes. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo F Everhart, M. D.

11/18, 1929 (Address) Windsor Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov. 19 19 29

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51063

CERTIFICATE OF DEATH.

18 -E 51063

1-PLACE OF DEATH Mt. Vernon Mills

City of BALTIMORE: (No. Falls Road & Chestnut St. 13-52 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond C. Roloson

(a) RESIDENCE NO. 3023 Keswick Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1912

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	17	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Beamer Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mt. Vernon Mills

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin B. Roloson

11 BIRTHPLACE OF FATHER (city or town) Milford

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Katie P. Myers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Katie Roloson

(Address) 3023 Keswick Road

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aupsy or inquiry.) were found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Neck Caught in Beamer Machine at Mt. Vernon Mills (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

11/16, 1929 (Address) 3632 Roland Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Nov. 18, 29

20 UNDERTAKER Joseph D. Cook ADDRESS 1003 West Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. The questions on OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 51064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 ✓ E 51064

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 819 N. Arlington Ave. St.) (Ward) 16-23

2-FULL NAME Andrew Molock

(a) RESIDENCE NO. 819 N. Arlington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary B Molock

6 DATE OF BIRTH (month, day, and year): Nov 20 1861

7 AGE: Years 67 | Months 11 | Days 25 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Talbot Co Md
(State or country)

PARENTS

10 NAME OF FATHER: John Molock

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: Chaudt.

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant: Mary B. Molock
(Address) 819 N. Arlington

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of brain
(Accident)

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Hartsuk M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem

DATE OF BURIAL: 11/19 19 29

20 UNDERTAKER: Emil Bernhardt

ADDRESS: 518 N Broadway

A. B. [illegible] tion should be carefully supplied. AGE should be stated EXACTLY. [illegible] OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 18 1929 [illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

E 51065

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51065

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Gunn

(a) RESIDENCE NO. 729 N Fremont Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

070

(c) Name of employer —

9 BIRTHPLACE (city or town) Unknown
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dennis Fantin

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Bumpe

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Maryland

14 Informant Hospital Records
(Address) Balto City Hosp.

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929 to Nov 16, 1929 that I last saw h alive on Nov 16 at 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis
Paget's Disease

(duration) Unknown

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 11-4-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X-ray.

(Signed) Fred M. Dunkwall, M. D.

11/16, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	11/19 1929
20 UNDERTAKER	ADDRESS
Ernest Beardsley	575 N Eutaw St

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 51066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | E 51066

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Penn Ave (WARD) 15-59

2-FULL NAME Kennith Talbott

(a) RESIDENCE NO. 2116 Penn Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 V yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Talbott

6 DATE OF BIRTH (month, day, and year): Aug 11th 1924

7 AGE — Years: 7 V | Months: 7 | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Bpk. House

(c) Name of employer: Temple Gardens

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Frank Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Lucy Talbott (Address) 2116 Penn Ave

15 Filed NOV 16 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/2 19 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7th 19 29 to Nov 15 19 29

that I last saw h alive on Nov. 14th 19 29

and that death occurred, on the date stated above, 3 A m.

The CAUSE OF DEATH* was as follows:

Suspicious Traumatic Orthopnea

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Pul. Tuberculosis

(duration) yrs. V mos. N ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. Lee Ellis M. D.

11/3 19 29 (Address) 924 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. Catonsville | DATE OF BURIAL: 11/5 19 29

20 UNDERTAKER: Frank J. Kennedy | ADDRESS: 578 N. Eutaw

mation should be carefully supplied. Note... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa... TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 ✓ E 51067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 4-16 St., Ward)

2-FULL NAME John Lamartina

(a) RESIDENCE NO. 749 W Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/30/1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fruit Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Bretonoro
(State or country)

PARENTS

10 NAME OF FATHER Angelo Lamartina

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Demarco

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Mrs A. Lamartina
(Address) 749 Saratoga St

15 Filed NOV 3 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hemoptysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Potter M. D.

11/17, 1929 (Address) 2 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 11-17 1929

20 UNDERTAKER Geo J Ruth — ADDRESS 1735 Hartford ave

tion should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. OCCUPATION is very important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51068

CERTIFICATE OF DEATH.

161 E 51068

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST., 6-9 WARD)

2-FULL NAME Baby Boy Goodman

(a) RESIDENCE NO. 12 Irving Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 11-16-29.

7 AGE — Years | Months | Days | If LESS than 1 day, 2 hrs. or 32 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Millie Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant Hosp. Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/17 1929.

17 I HEREBY CERTIFY, That I attended deceased from 11-16, 1929, to 11-17, 1929.

that I last saw h alive on 11-17, 1929.

and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Michael Gwozdd M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodmen Circle, Helmes Rd. Carroll — DATE OF BURIAL 11-18-1929

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E Balto.

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51069

CERTIFICATE OF DEATH

90 E 51069

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 S. Bond St. 3-4 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathan Newhouse

(a) RESIDENCE NO. 303 S. Bond st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Newhouse

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harris Newhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto st

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 13- 1929, to Nov 17 29, 19, that I last saw h— alive on Nov 16- 19 29 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular dis — Chronic

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Contracture

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Fred C Brandt, M. D.

19 (Address) 125 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Behrer Rosedale

DATE OF BURIAL 11/18 19 29

20 UNDERTAKER Jack Lewis 1439 E Balto st

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 51070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 ✓ E 51070

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1133 Cleveland St. 21-29 Ward)

2-FULL NAME John J. McGarvey

(a) RESIDENCE NO. 1133 Cleveland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26, 1873

7 AGE: Years 56 Months 4 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) alg

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Patrick McGarvey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. J. Fitz

(Address) 1133 Cleveland

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. J. Brooks M. D.

(Coroner)

Nov 17 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Date of Burial 11/18 1929

20 UNDERTAKER J. M. Cook ADDRESS 1217 E. Fayette St

tion should be carefully supplied. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificate.

NOV 18 1929 REGISTRAR'S OFFICE

Cor.—10-10-29—A Co.—100 Blks.

E 51071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 51071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 11-7 Ward)

2-FULL NAME Irvin Lewis

(a) RESIDENCE NO. 627 N. Calvert St. (Usual place of abode)

St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7 - 1880

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
49	0	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Long Construction Co

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Martin Lewis

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margt. Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ed. Lewis
(Address) 627 N Calvert

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 - 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fract. Skull Internal
Intracranial Bleeding
Shock (duration) ..... yrs. 1/2 mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Special Examination Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Wm. J. Kelly, M. D.
Oct. 19 29 (Address) 1034 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Ind — DATE OF BURIAL 11/18 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

tion should be carefully supplied. AGE should be stated. [illegible]
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51072

CERTIFICATE OF DEATH

177-001 E 51072

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent Urbano

(a) RESIDENCE NO. 212 Eastern Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Urbano

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: 41 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Domico Urbano

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Italy

12 MAIDEN NAME OF MOTHER: Tricita ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Italy

14 Informant: (Name illegible) (Address) BALTIMORE CITY HOSPITALS

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-17-29

17 I HEREBY CERTIFY, That I attended deceased from 11-15, 1929, to 11-17, 1929, that I last saw him alive on 11-17, 1929, and that death occurred, on the date stated above, at 7-20 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Anemia, Pernicious

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10-29-29

Was there an autopsy? No omentpotency

What test confirmed diagnosis? Wassermann & Lab. Examination

(Signed) Marvin A. Levy, M. D.

11-17, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov. 19, 1929

20 UNDERTAKER: Wendell J. Lippel — ADDRESS: 310 S. Eden

Important: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51073

122-001

E 51073

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 N Hamburg ST. 11-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Gansmann

(a) RESIDENCE NO. 708 N Hamburg ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 13 1867

7 AGE: Years 62 | Months 4 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): Driver

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Gansmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hannah Galvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lena Hossman

(Address) 708 N Hamburg St

15 Filed 11-19 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-16-29

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to Nov 16, 1929, that I last saw him alive on Nov 15, 1929 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Aortic Insufficiency (Chronic Endocarditis)

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) O Hamm, M. D.

19 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk — DATE OF BURIAL: 11-19 1929

20 UNDERTAKER: Edward C Clarke, 1000 Stace St — ADDRESS

Important.—See instructions on back of

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51074

CERTIFICATE OF DEATH

46 E 51074

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 736 N Fulton Ave ST. 46-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie J Connelly.

(a) RESIDENCE NO. 736 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos Connelly

6 DATE OF BIRTH (month, day, and year) Nov 3 186[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Francis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Hannah Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Geo Whaley

(Address) 736 N Fulton Ave

15 Filed ..... 19 .....

Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1929 to Nov 16th 1929, that I last saw her alive on Nov 16th 1929 and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

CONTRIBUTORY (Secondary) Malignant Degeneration of Breast (duration) yrs. 4 mos. da.

a Breast (duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Gressick, M. D.

Nov 16 1929 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Spicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 11-19 1929

20 UNDERTAKER Chas S Harker

ADDRESS 115 E Mosher

Spec.—2-29-28—L. F. S.—500 Bks.

E 51075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

41 E 51075

1—PLACE OF DEATH

Guilford REGISTERED NO.

CITY OF BALTIMORE: (No. 3904 Greenway ST. 41-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriet V Blake

(a) RESIDENCE NO. 3904 Greenway ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Aug 1st 1872

7 AGE — Years: 57 — Months: 3 — Days: 19 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George A Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Harriet A Griggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Miss Julia Blake

(Address): 3904 Greenway

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-18-1929

17 I HEREBY CERTIFY, That I attended deceased from ..., 1926, to Nov 18, 1929, that I last saw h[er] alive on Nov 17, 1929 and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation following myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward, M. D.

19 (Address) 1212 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: 11 20 1929

20 UNDERTAKER: E & B. Hale — ADDRESS: 115 E West St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51076 90 E 51076

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1218 Bayard St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mather Gross

(a) RESIDENCE NO. 1218 Bayard St. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Alberta Gross

6 DATE OF BIRTH (month, day, and year)

7 AGE: 52 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co.

PARENTS

10 NAME OF FATHER: Matthew Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co.

12 MAIDEN NAME OF MOTHER: Tilla Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Md

14 Informant: Anna Gross
(Address) 1218 Bayard st.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/16/24.

17 I HEREBY CERTIFY, That I attended deceased from 10-24-24 19 to 11-16-24 19, that I last saw him alive on " 19, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. M. Cardozo, M. D.

11-18-24 (Address) 1574 N. Hilldale.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvert Co. Md — DATE OF BURIAL: Nov. 18 1924

20 UNDERTAKER: Walter B. Spriggs — ADDRESS: 139 N. Hanley st

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

51078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 51078

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 E Fayette ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Mary

(a) RESIDENCE NO. 1604 E Fayette ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word):

6 DATE OF BIRTH (month, day, and year): 11-14-29

7 AGE: Years | Months | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Benny Hillen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ruby Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Robt M. Donald

(Address): 1604 E Fayette

15 Filed: 4073 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-17-29

17 I HEREBY CERTIFY, That I attended deceased from 11-14, 1929, to 11-17, 1929, that I last saw h[illegible] alive on 11-16, 1929, and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

(a) Premature infant

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physician

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11-17 1929 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

NOV 18 1929

Important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 51078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51078

1—PLACE OF DEATH

REGISTERED NO. 5679

CITY OF BALTIMORE: (No.) South Baltimore General ST. (WARD) Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George C. Rhodes

(a) RESIDENCE NO. 30 ½ Walbrook ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John L Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Margaret Clayey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John L Rhodes
(Address) 3205 Catalpha Rd

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16-29

17

I HEREBY CERTIFY, That I attended deceased from 11-5, 1929, to 11-16, 1929, that I last saw h[illegible] alive on 11-16, 1929 and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Arteriosclerosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical Signs

What test confirmed diagnosis?

(Signed) Joseph Laubheim M. D.

19 (Address) South Baltimore Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Nov 19 1929
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

Important. See instructions on back of certificate.

18 1929 C. HAMPSON JONES, M.D. Registrar

Spec.—1-12-23—M&T—500 Blks.

E 51079 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51079

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital 129

CITY OF BALTIMORE: (No. 1000 Caton Ave St. 13-54 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Eckenrode

(a) RESIDENCE No. 2859 Woodbrook Road WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maurice A Eckenrode

6 DATE OF BIRTH (month, day, and year) April 21 78

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) United R R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Emanuel E—

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Duval

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maurice A Eckenrode
(Address) 2859 Woodbrook

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1929, to Nov. 17, 1929, that I last saw h— alive on Nov. 16, 1929, and that death occurred, on the date stated above, at 12-10A m.

The CAUSE OF DEATH* was as follows:

chronic nephritis
chronic myocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Nov 20 1929

20 UNDERTAKER W M Rountree — ADDRESS 223 W Pratt

SEE INSTRUCTION is very important See instructions on back of certificates.

E HAMPSON JONES M D

Spec.—2-29-28—L. F. S.—500 Bks.

(Shakespear)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51080 × 90 E 51080

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 12-44

CITY OF BALTIMORE: (No. 423 Merryman Av ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Henry Shakespeare

(a) RESIDENCE NO. 423 Merryman Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Shakespeare

6 DATE OF BIRTH (month) March 14th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) Caroline Co. (State or country) Va

PARENTS

10 NAME OF FATHER Beverly Shakespeare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sallie Shakespeare
(Address) 423 Merryman Lane

15 Filed ....., 19 .....
C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) November 16/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 19 29, to Nov 16th, 19 29

that I last saw him alive on Nov 16th, 19 29

and that death occurred, on the date stated above, at 10.35 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Yungstrup III M. D.

11/17 19 29 (Address) 49 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodford Va.

DATE OF BURIAL Nov. 18 1929

20 UNDERTAKER Wm. R. A. Elliott

ADDRESS 1725 Ashland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 V E 51081

1—PLACE OF DEATH

REGISTERED NO. 1567

CITY OF BALTIMORE: (No. 2935 Walbrook Ave. DIST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Lehmen

(a) RESIDENCE NO. 2935 Walbrook Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. ~ mos. ✓ ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J Lehmen

6 DATE OF BIRTH (month, day, and year) Feb 13, 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cost Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Geo A Lehmen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Sarah J Rohrer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Mary J Lehmen
(Address) 2935 Walbrook Ave.

15 Filed [illegible], 19 [illegible] Registrar
G. HAMPSON JONES, M.D.

DEC 8 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1927, to Nov 18, 1929, that I last saw him alive on Nov 17, 1929 and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH* was as follows: Multiple Sclerosis

(duration) 4 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Robert Wooley, M. D.

, 19 (Address) 2530 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Western — DATE OF BURIAL 19

20 UNDERTAKER Geo W Little — ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51082

CERTIFICATE OF DEATH

24-001

E 51082

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 1434 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Cecelia Rhoades

(a) RESIDENCE NO. 117 E Barney St. (Barney St) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Rhoades

6 DATE OF BIRTH (month, day, and year) May 17/1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49	6 mos	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER William Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Glacall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Hattie C Bauer

(Address) 117 E Barney st.

15 Filed NOV 18 1929 C. HUNTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18, 1929

17

I HEREBY CERTIFY, That I attended deceased from November 1, 1929, to November 18, 1929, that I last saw h.er alive on November 17, 1929 and that death occurred, on the date stated above, at 6 50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M B Schreiber, M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL 11/20/29

20 UNDERTAKER Joseph Ahrens

ADDRESS 22 Rutland

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51083

CERTIFICATE OF DEATH

45 E 51083

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 7-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E. Matthai

(a) RESIDENCE NO. 3223 Abell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced MUSBAND of ~~(or) WIFE of~~ Rose Matthai

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Christian Edward Matthai

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ann Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. B. Matthai (Son)

(Address) 3223 Abell Ave.

15 Filed OCT 8 1929, 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929, to Nov. 16, 1929, that I last saw him alive on Nov. 16, 1929, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) Undetermined yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 11, 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) ~~L. P. Hirst~~ George H. Yeager, M. D.

11/16, 1929 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov. 19 1929

20 UNDERTAKER: Henry Sander & Sons, Inc.

ADDRESS: Baltimore St. & Broadway

E 51084 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51084

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Corral

(Residence in Baltimore: No. in rear 1614 Thames St St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: April (Month) 25 (Day) 1929 (Year)

7-AGE: ....yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Raymond Corral

11-BIRTHPLACE OF FATHER, (State or Country): Spain

12-MAIDEN NAME OF MOTHER: Celestina Sierra

13-BIRTHPLACE OF MOTHER, (State or Country): Spain

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Raymond Corral (Father)

(Address) 1614 Thames St.

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 8 (Day) 1929 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-Pertussis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Collins M. D.
(Coroner)

11/13/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: Nov. 19 1929

20-UNDERTAKER: Henry Sander & Sons, Inc.

ADDRESS: Baltimore St. & Broadway

This CAUSE OF DEATH is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 51035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3338 Strickland St. (Ward) 20-7074

2-FULL NAME Alice Prescott Riegel

(a) RESIDENCE NO. 3338 Strickland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 65 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Lewis Riegel

6 DATE OF BIRTH (month, day, and year): About 1864

7 AGE — Years: About 65 — Months: 0 — Days: 0 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Balto.

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Mr. Prescott

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mrs Conley

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Maryland

14 Informant: Mrs Eln. Magill (Cousin)

(Address): Catonsville-Md.

15 Filed ....., 19 ..... Registrar

HAMPSON JONES

NOV 18 1929

Per ..... Clk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

a) Coronary Thrombosis.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. O'Brien M. D. (Coroner)

Nov 16, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial 11/19/29.

20 UNDERTAKER: Stewart & Moser — ADDRESS: Balto. Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51086

1—PLACE OF DEATH

REGISTERED NO. 1936-37

CITY OF BALTIMORE: (No. 3413 Mt Pleasant ave ST. 36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Townsend

(a) RESIDENCE NO. 3413 Mt Pleasant ave ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David A. Townsend

6 DATE OF BIRTH (month, day, and year) May 7 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gottlieb Lutzau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Adelaide Bache

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant David A. Townsend
(Address) 6 E Conklin St

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar
NOV 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Nov 17, 1929, that I last saw her alive on Nov 16, 1929 and that death occurred, on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tichnor, M. D.

10/17, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cem	Nov 19 1929
20 UNDERTAKER	ADDRESS
John C. Miller	2436 E Oliver

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51087 HEALTH DEPARTMENT—CITY OF BALTIMORE É 51087

CERTIFICATE OF DEATH

167-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 503 W. Pratt St. 12-30 Ward)

2-FULL NAME Charles H. Goudy

(a) RESIDENCE NO. 503 W. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 59 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer: Self

9 BIRTHPLACE (city or town)
(State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Goudy

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Susanna White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Balto. Md.

14 Informant: Frank G. Faurot
(Address): Washington, D. C.

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Poisoned by Carbon Monoxide.
Illuminating Gas.
Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Fillers M. D.

11/18. 1929. (Address) 2737 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: 11/19/1929

20 UNDERTAKER: Wm Cook 1217 — ADDRESS: St Paul st

NOV 19 1929

Please Print Clearly. Application Should Be Carefully Examined Before Signing. Every Item Should Be Correctly Answered. Particular Attention Should Be Given to the Statement of OCCUPATION as Very Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Schenuit 1337 S Charles St

E 51038

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51038

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3100 Old Annapolis Rd ST. (WARD) 25-75

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M Handschuh

(a) RESIDENCE NO. 3100 Old Annapolis Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 5. 1848

7 AGE — Years: 81 | Months: 3 | Days: 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John M Handschuh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John M Handschuh

(Address) 3100 Old Annapolis Rd

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15. 1929. to Nov 18. 1929. that I last saw h alive on Nov 18. 1929. and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary) Chr Valvular Endocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John M. Schenuit M. D.

19 (Address) 1337 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 11/20 1929

20 UNDERTAKER: J. M. Cook

ADDRESS: 1217 E Pratt St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51089

CERTIFICATE OF DEATH

23 E 51089

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST. 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Keyes

(a) RESIDENCE NO. 5002 Gunther ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer T.

6 DATE OF BIRTH (month, day, and year) Jan 18th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER John L Gagliardi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Adeline Gagliardi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Elmer T. Keyes

(Address) 5002 Gunther Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16 1929, to Nov. 18, 1929, that I last saw her alive on Nov. 18, 1929 and that death occurred, on the date stated above, at 7:45 p. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) 0 yrs. 0 mos. 12 hrs.

18 Where was disease contracted if not at place of death? presumably at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Microscopy is being awaited

(Signed) Sasha F. Ginghia, M. D.

11/18/1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 11/21/1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51090

CERTIFICATE OF DEATH.

170 E 51090

1-PLACE OF DEATH

City of BALTIMORE. (No. Rear 5700 Winner Ave Ward) 27-55

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Frederick Koty

(a) RESIDENCE NO. 5700 Winner Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 8 mos. 24 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 22 1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	24	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Frederick H Koty

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Arnold

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. (State or country) Md

14 Informant Mr Frederick H Koty (Address) 5700 Winner Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot wound Through head Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) John H Timmes (Coroner) M. D.

11/15. 1929 (Address) 802 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Nov. 18 1929

20 UNDERTAKER Wm Pickner & Son ADDRESS North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

83 ✓ E 5109I

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5002 Liberty Hts Ave ST. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie L. Hawkins.

(a) RESIDENCE NO. 5002 Liberty Hts Ave. ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 60 yrs. 8 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Hawkins.

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles L. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. W. Lee Hawkins

(Address) 5002 Liberty Hts Ave.

15 Filed NOV 19 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13 – 1929 to Nov. 16 – 1929

that I last saw h[illegible] alive on Nov. 16 – 1929

and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

CONTRIBUTORY (Secondary) Arterio Sclerosis - Cerebral (duration) yrs. mos. 5 ds.

Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clin. Exam.

(Signed) J. Howard Brown, M. D.

(Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL Nov 19 1929

20 UNDERTAKER Wm Fickner Sons

ADDRESS North & Pa

IMPORTANT: SEE INSTRUCTIONS ON REVERSE SIDE

NOV 19 1929 HAMILTON JONES, M. D. Registrar

Spec.—2-29-28—L. F. S.—500 Blks.

E 51092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 51092

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 4302 Maine Ave (St.) (Ward) REGISTERED NO. 28-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Virginia Bates

(a) RESIDENCE NO. 4302 Maine Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs 10 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. da.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joshua A. Bates

6 DATE OF BIRTH (month, day, and year): Jan. 7 1853

7 AGE — Years: 76 | Months: 10 | Days: 9 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Robert W. Register

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susanna Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant: Mr. Joshua A. Bates

(Address) 3601 Forest Park Ave.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June —, 1926, to Nov 16, 1929, that I last saw h alive on Nov 15, 1929, and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Myocardeal Insufficiency
Cerebral Haemorrhage.

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary): Cardio Vascular disease. nec Hypertension

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? , Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carlton M. Thompson, M. D.

11/17, 1929 (Address) 2806 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 19 1929
20 UNDERTAKER: Wm. J. Rickert Sons	ADDRESS: North Ave

Important: Use black ink in writing.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51093 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 ✓ E 51093

REGISTERED NO. 14-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Division ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecilia Cooper

(a) RESIDENCE NO. 2103 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank T. Cooper

6 DATE OF BIRTH (month, day, and year) June 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Joseph Holton

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Sylvia Nyhis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14

Informant Eva Turner

(Address) 2103 Division St

15

Filed ..... 19 .....

H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 5, 19 29, to Nov 15, 19 29, that I last saw h e alive on Nov 14, 19 29 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mania a Potu Cirrhosis of Liver

Removed 14 months ago

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. N. Wright, M. D.

11/16, 19 29 (Address) 1204 Preston Ave St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/19/1929

UNDERTAKER Thos. H. Holland

ADDRESS 1631 Druid Hill Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51094 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 51094

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1713 Division ST. 14-20 (WARD)

2-FULL NAME Florence Bailey

(a) RESIDENCE NO. 1713 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 5 1902

7 AGE: Years 27 Months 4 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): 0?1

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Benjo Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Louise Upshur

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Maggie Greene

(Address) 1713 Division St.

15 Filed ..... 19 ..... C. H. JOHNSTONE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 — 1929 to Nov 15 — 1929.

that I last saw her alive on Nov 15 — 1929.

and that death occurred, on the date stated above, at 4 P — m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) La Grippe — in 1928 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bane M. D.

19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 11/17 1929

20 UNDERTAKER: Chas. H. Alexander — ADDRESS 1906 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Zakościelny.

E 51095

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 ✓

CERTIFICATE OF DEATH

E 51095

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S. Rose St ST 1-3 WARD)

2—FULL NAME Baby Zakościelny

(a) RESIDENCE NO. 713 S Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 800

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Balto.

PARENTS

10 NAME OF FATHER James Zakościelny

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Rosa Czajkowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant James Zakościelny

(Address) 713 S Rose St

15 Filed 1 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 18, 1929, that I last saw him alive on Nov 18, 1929 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

a Atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Thy Daniel, M. D.

(Address) 801 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Nov 19	1929
20 UNDERTAKER	ADDRESS
J W Ozgowski 19	30 Eastern Ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51096

CERTIFICATE OF DEATH

E 51096

REGISTERED NO. 203

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St., 4-30 Ward)

2-FULL NAME Clayton Sylvester Dellinger

(a) RESIDENCE NO. Cockeysville St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Dellinger

6 DATE OF BIRTH (month, day, and year) Feb - 22 - 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	51	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa

PARENTS

10 NAME OF FATHER Wm Dellinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Fannie Young

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Mrs. Rose Emma Dellinger
(Address) Cockeysville, Md

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Base Skull
Run down by auto while walking on road
1 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Traumatic Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York Rd 1/2 mi below Warren Rd
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. Frame, M. D.
11/19, 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem, Balto Co, Md	Nov 21 1929
20 UNDERTAKER	ADDRESS
Wm C. Brooks & Sons	Sparks Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 51097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Johns Hopkins Hosp St., Ward)

2-FULL NAME Edw Rybarczyk

(a) RESIDENCE NO. 320 S Washington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Child

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb - 24 - 1922

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER Stanley Rybarczyk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Kalee Padowske

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Stanley Rybarczyk
(Address) 320 S Washington St

15 Filed ....., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract of skull - Struck & run over by rear wheels of a truck (Left)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Compression Haemorrhage of Brain

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Wash & Eastern

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H J Braun, M. D.

11/19 19 29 (Address) 2939 W 2nd Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Kost — DATE OF BURIAL 20 1929

20 UNDERTAKER J W Bazgurski 1930 — ADDRESS Easton Av

Use Medical Terms. Cause of Death must be certified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec —8-16-29—L. F. S.—100 Bks.

E 51098 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51098

CERTIFICATE OF DEATH

25-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 1715 Guilford Ave ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Coburn

(a) RESIDENCE NO. 1715 Guilford Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of J. H. Coburn

6 DATE OF BIRTH (month, day, and year) Jan. 9 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edw. Burns

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Catherine Burns

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Catherine E. Powers

(Address) 1715 Guilford Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18-1929

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 14 to Nov 18 19 29, that I last saw h alive on Nov 17 19 29 and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemaplegia

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis of left side.

(Signed) E. T. Bouchelle, M. D.

19 (Address) 2104 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 20 1929

20 UNDERTAKER Henry H. Jenkins Son Co

ADDRESS McCulloh and St.

important. See instructions on back of certificate.

V 1 6 1929 H. [illegible] JONES, M.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51099

CERTIFICATE OF DEATH

188-103

E 51099

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp St., 5-8 Ward)

2-FULL NAME Mildred Jordon

(a) RESIDENCE NO. 1211 E Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Chld

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): 4/20

7 AGE: Years 9 | Months 8 | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): no
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Jos Gordon

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Eleanora Wicks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant (Address): James Jordan 1211 E Lexington St

15 Filed ..., 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck by car
Ran down while crossing street (not at intersection) after passing from in front of parked auto
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Traumatic Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cor Central & Lexington Ave

Did an operation precede death? died during operation Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H J Frame M. D.

11/18 1929 (Address) 2909 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem

DATE OF BURIAL: 11-19 1929

20 UNDERTAKER: Bayard Wright

ADDRESS: 1218 McCulloh St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51100 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 51100

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Young

(a) RESIDENCE NO. 915 McDonough St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Isaac Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mollie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records of
(Address) Baltimore City Hosp.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to Nov. 17, 1929

that I last saw him alive on Nov. 17, 1929

and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) Syphilis of cerebral vessels

(duration) over 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Contributory at Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Wassermann Reaction.

(Signed) Fred M. Dunkenwald M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL 11-20 1929

20 UNDERTAKER Byron Wright ADDRESS 1218 McElderry St

Important. See instructions on back

Spec.—8-16-29—L. F. S.—100 Blks.

E 51101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 51101

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 W. Balto St ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chase Jacobs

(a) RESIDENCE NO. 1432 W. Balto St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Jacob

6 DATE OF BIRTH (month, day, and year) Sept 10-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/29

17 I HEREBY CERTIFY, That I attended deceased from 11/14, 1929, to 11/18, 1929, that I last saw h— alive on 11/18, 1929 and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... M. D.

11/18, 1929 (Address) 1727 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Cem	11/19, 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

Spec.—7-17-26—A Co.—200 Bks.

E 51102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

25-001 E 51102

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1435 E. Fort Ave St. 24-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Miller.

(a) RESIDENCE NO. 1435 E. Fort Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 4 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leah J. Miller.

6 DATE OF BIRTH (month, day, and year): Feb. 21, 1859.

7 AGE: Years 70, Months 9, Days 4. IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Miller.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Dont know.

12 MAIDEN NAME OF MOTHER: Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Leah J. Miller.

(Address): 1435 E. Fort Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1/29, 19..., to Nov 17/29 19..., that I last saw h.. alive on Nov 17/29, 19..., and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia, (Cerebral)

(duration) ... yrs. ... mos. 17 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno B Coll, M. D.

Nov 19/29 (Address) 1203 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Carmel Bem	Nov 20 1929
20 UNDERTAKER	ADDRESS
A. Edward Evans	35 E Fayette

NOV 19 1929 C. HAMILTON JONES

Registrar

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001 E 51103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 7 N. Heath St. St. 23-32 Ward)

2-FULL NAME Mary Thelma Schmidt.

(a) RESIDENCE NO. 7 N. Heath St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~HUSBAND~~ HUSBAND (or) WIFE of Howard J. Schmidt.

6 DATE OF BIRTH (month, day, and year) January 8, 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	19	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George Potee.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Pearl Vogel.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co. Md.

14 Informant Howard J. Schmidt. (husband)
(Address) 7 N. Heath St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning
Suicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leinhardt, M. D.

11/19 1929 (Address) 1019 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. — DATE OF BURIAL Nov 20 1929

20 UNDERTAKER A. Howard Evans — ADDRESS 35 E. Fayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.--2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51104 — 24-001 — E 51104

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Howard

(a) RESIDENCE NO. 1124 McCulloh St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of
(Address) Balto. City Hosp.

15 Filed ____ 19 ____ Registrar

NOV 19 1929 RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929 to Nov. 16, 1929

that I last saw her alive on Nov. 16, 1929

and that death occurred, on the date stated above, at 5:15 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) ____ yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

Hypertension (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gennal exam.

(Signed) Fred M. Dunkenfield M. D.

.19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lud Cemetery

DATE OF BURIAL: Nov 20 1929

20 UNDERTAKER: John H Owens

ADDRESS: 538 2nd St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51105

CERTIFICATE OF DEATH

90 ✓ E 51105

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 E Monument ST. 29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Kumlehn

(a) RESIDENCE NO. 1933 E. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H C F Kumlehn

6 DATE OF BIRTH (month, day, and year) Jan 19, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bruggemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Rena Feiser

(Address) 4106 Northern Parkway

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17 1929

17

I HEREBY CERTIFY, That I attended deceased from September 16, 1929, to November 17, 1929, that I last saw h alive on November 17, 1929, and that death occurred, on the date stated above, at 5 1 09 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Jayd, M. D.

Nov 18, 1929 (Address) 2065 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov 20 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51106

CERTIFICATE OF DEATH

188-103 ✓

E 51106

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Joseph's Hosp (St.) N-40 (Ward)

2-FULL NAME Alfred A Kershaw

(a) RESIDENCE NO. 3702 Ewing Ave St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Katharine Kershaw

6 DATE OF BIRTH (month, day, and year) Dec - 14 - 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Mechanics
(c) Name of employer

9 BIRTHPLACE (city or town) Lynchburg
(State or country) Va

PARENTS

10 NAME OF FATHER Alford Kershaw

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Dora Stern

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Katherine Kershaw
(Address) 3702 Ewing Ave

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17/1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Central Hemorrhage - (cut lung left (struck by an automobile which he walked in front of following his passing from behind parked car

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Compression

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? opposite 3234 Belair Rd on nov 1-1929

Did an operation precede death? no Date of .....

Was there an autopsy? yes —.

What test confirmed diagnosis? Clinical

(Signed) H J Frame, M. D.

11/18/1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL Nov 20 1929

20 UNDERTAKER John Ulrich — ADDRESS 208 S Adams

Spec.—2-29-28—L. F. S.—500 Bks.

E-51107 HEALTH DEPARTMENT—CITY OF BALTIMORE E-51107

CERTIFICATE OF DEATH 33

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Alston

(a) RESIDENCE NO. 608 S. Fremont ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eunice Alston

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Kemper Alston

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Carrie Glymph

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Nov. 16, 1929, that I last saw him alive on Nov. 16, 1929 and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

Indefinite (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Serondary) Pleurisy & Effusion

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hus Harwood, M. D.

11-16 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-18 1929
20 UNDERTAKER	ADDRESS 916 Pa ave
Dennis Easton	

Important. Use instructions on

Cor.—10-10-29—A Co.—100 Bks.

E 51108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 51108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 213 N. Poppleton St. 16 Ward)

2-FULL NAME John W. Daniels (Jr)

(a) RESIDENCE NO. 213 N. Poppleton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 - 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	2	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Daniels

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N C

12 MAIDEN NAME OF MOTHER Jennie Terrell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Mrs J. Daniels
(Address) 213 N. Poppleton St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

11/18 1929 (Address) 729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11 19 1929
20 UNDERTAKER	ADDRESS 916
Dennis Easton	Bmore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51109

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 333 W Biddle St., 11-24 Ward)

2-FULL NAME Lizzie Wilkins.

(a) RESIDENCE NO. 333 W Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work nv
(b) General nature of industry, business, or establishment in which employed (or employer) nv
(c) Name of employer nv

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant
(Address) Ida Lewis 333 W. Biddle St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ..... (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Chronic Myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-19 1929

20 UNDERTAKER Lewis Eaton

ADDRESS 916 Ea

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51110

CERTIFICATE OF DEATH

188-103

E 51110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 10-14 Ward)

2-FULL NAME Margaret L. Klees

(a) RESIDENCE NO. 927 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F. Klees

6 DATE OF BIRTH (month, day, and year) Nov-1-1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69		16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hawk
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo P. Ohlgart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha Engel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant William F. Klees
(Address) 5202 20th st

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Run down by auto while crossing street against red light (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hanford Ave & Biddle

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) J. J. Crane M. D.

11/18. 1929 (Address) 2939 Md Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 21 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1120 E Monument St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF ~~BALTIMORE~~

E 51111 — CERTIFICATE OF DEATH — E 51111

1—PLACE OF DEATH South Balto., Jno. Hop. — REGISTERED NO. 161-001

CITY OF BALTIMORE: (No. 1 ST., 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Housley

(a) RESIDENCE NO. 868 Carroll Av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/18/29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1 hr				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Jno. P. Housley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y. N. Y.

12 MAIDEN NAME OF MOTHER Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother
(Address) 868 Carroll Av.

15 Filed 4075 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-29

17 I HEREBY CERTIFY, That I attended deceased from 11-18-, 1929 to 11-18, 1929

that I last saw him alive on 11-18, 1929

and that death occurred, on the date stated above, at 11 30 A.m.

The CAUSE OF DEATH* was as follows:

Premature Birth - 4½ mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis W. Lillie Jr. M. D.

, 19 (Address) S. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

NOV 18 1929

Spec.—2-20-28—L. F. S.—500 Blks.

E 51112

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51112

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 90

CITY OF BALTIMORE: (No. 213 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. Harris

(a) RESIDENCE NO. Henrietta St. near Warner ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male 32	C	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Cornelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed ... 19 ... Registrar

4077 11/4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1929, to Nov. 12, 1929, that I last saw him alive on Nov. 12, 1929 and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophy, Chronic: Glomerulonephritis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. PE

(Signed) Warren H. Hill Lean, M. D.

11/14, 1929 (Address) Balto. City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL ... 19

20 UNDERTAKER: C. HAMPSON JONES, M. D. Commissioner of Health

ADDRESS: NOV 19 1929

Important. See instructions

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51113
1—PLACE OF DEATH

CERTIFICATE OF DEATH

45 E 51113

CITY OF BALTIMORE: (No. Balto. City Hospitals ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Sawicki

(a) RESIDENCE (Usual place of abode) NO. 1713 E. Pratt ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Vincent Sawicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital record

(Address)

15 Filed 19 4078 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-29

17

I HEREBY CERTIFY, That I attended deceased from 9-13, 1929, to 11-15, 1929, that I last saw h~~im~~ alive on 11-15, 1929 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma rectum

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 9-13-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

11-15, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner

ADDRESS

NOV 19 1929

8 Important: See instructions on reverse side.

WM. H. HARRISON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51114

HEALTH DEPARTMENT—CITY OF BALTIMORE

TH-002

E 51114

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 76 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Doe

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45?	Unknown			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Balto. City Hospitals

15 Filed 12 4079 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1929 to Nov. 13, 1929

that I last saw h im alive on Nov. 13, 1929

and that death occurred, on the date stated above, at 10:15 AM

The CAUSE OF DEATH* was as follows:

Thrombosis Cerebral, syph. ?
at Meningitis

(duration) yrs. mos. ?? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P.C.

(Signed) Marcia Tillotson M. D.

11-14, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS NOV 19 1929

Important. See instructions

E. T. WOOD

Spec.—2-29-28—L. F. S.—500 Bks.

E 51115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 51115

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 342 S Stricker ST., 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Phillip Ganley

(a) RESIDENCE NO. 342 S Stricker ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Florena M Ganley

6 DATE OF BIRTH (month, day, and year) March 7 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7 8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs A Ganley

(Address) 342 S Stricker

15 Filed NOV 19 1929 19 H.H.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1929, to November 17, 1929, that I last saw h[illegible] alive on November 17, 1929 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation and uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senile arterio-sclerosis, compounded, interstitial nephritis (duration) over yrs. 3 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) Mary C. Pike M. D.

11-18, 1929 (Address) 1203 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/20 1929
20 UNDERTAKER	ADDRESS
Smyth & Farley	Fulton & Fayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51116

CERTIFICATE OF DEATH

197

E 51116

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Pagliara

(a) RESIDENCE NO. 205 Albemarle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mon. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Pagliara

6 DATE OF BIRTH (month, day, and year) Nov 24/1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Pagliara

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Frances Accardo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Margaret Pagliara
(Address) 205 Albemarle St.

15 Filed ..., 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/29 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in neck injuring spinal cord.
(Homicide)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Jos. A. Coen, M. D.

11/19/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 21 1929

20 UNDERTAKER Wendel & Kappel — ADDRESS 300 S Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51117

CERTIFICATE OF DEATH

49 E 51117

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1530 Hollins ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Bisese

(a) RESIDENCE NO. 1530 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Mariano Bisesi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore 1530 Hollins St

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

NOV 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to Nov. 17, 1929, that I last saw h in alive on Nov. 17, 1929 and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Malignant Neoplasm, left kidney

(duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of July 1929

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) W. S. Dippell, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 20 1929
20 UNDERTAKER Fleming Keehne	ADDRESS 133 Hollins

Important. See instruction on back of Certificate

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51118

CERTIFICATE OF DEATH.

16 1 E 51118

1-PLACE OF DEATH

City of BALTIMORE: (No. 1037, Myrtle Ave St. 17-24 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Wells

(a) Residence No. 1037, Myrtle Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 15 Nov, 1929

7-AGE. — yrs. — mos. 2½ ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Martell Fryl

11-BIRTHPLACE OF FATHER (city or town) unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Hattie Mae Wells

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), North Carolina

14-

(Informant)

(Address)

15-

Filed 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11 / 18 / 29

17- I HEREBY CERTIFY, That I attended deceased from 15 Nov, 1929 to 18 Nov, 1929

(that I last saw him alive on 17 Nov, 1929

and that death occurred, on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

New born infant, premature

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Inanition

(Duration) — yrs. — mos. 2 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel D Drake M. D

, 1929 (Address) Hopkins Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL, 19

20-UNDERTAKER, Commissioner Health

ADDRESS

NOV 1

Please print carefully. See instructions on back of certificates.

9 1929 HARRISON JONES, M. D.

4081 ARS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51119

CERTIFICATE OF DEATH.

161-001 E 51119

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2527 Pennsylvania Ave. Ward) 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Moore

(a) RESIDENCE NO. 2527 Pennsylvania St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
November 18, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day 12 hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Woodruff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Atlantic City, New Jersey

12 MAIDEN NAME OF MOTHER Elizabeth Moore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Salisbury, Md.

14 Informant Th. Antigiani

(Address) 2942 E. Fayette St.

15 Filed ....., 19 .....

Registrar

1924080 RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from November 18, 19 29, to November 19, 19 29, that I last saw living at native on November 19, 19 29, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos. 12½ Hours ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Th. Antigiani, M. D.

, 19 (Address) 2942 East Fayette Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL. Date of Burial 19

20 UNDERTAKER C. H. EMERSON JONES, M. D. ADDRESS

Commissioner Health.

NOV 19 1929

OF DEATH in plain terms, so that it may be properly classified. Items are very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51120

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2875 Mayfield ST. 8-45 WARD)

2-FULL NAME Caroline Wilhelmina Leembach

(a) RESIDENCE NO. 2875 Mayfield ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Leembach

6 DATE OF BIRTH (month, day, and year) Jan. 3 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Germany

PARENTS

10 NAME OF FATHER Wm Wöller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Helen Koerner

(Address) 2875 Mayfield Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 13, 1929. to Nov. 18, 1929.

that I last saw her alive on Nov 18, 1929,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas W. Edwards, M. D.

, 19 (Address) 2746 Alameda Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Nov 21 1929

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son — ADDRESS 801 W. Fayette

CAUSE OF DEATH IS TO BE FILLED IN BY PHYSICIAN. INFORMATION is very important. See instructions on back of certificates.

NOV 19 1929

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24001 E 51121

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 209 Ridgewood Road ST. 27-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth S. Dorsey

(a) RESIDENCE NO. 209 Ridgewood Road ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel B. Dorsey

6 DATE OF BIRTH (month, day, and year) June 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER William Whitelock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Jane Stockton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mary D. Pagon
(Address) 209 Ridgewood Road

15 Filed Nov 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 19 29, to Nov 18th, 19 29, that I last saw h[er] alive on Nov 17th, 19 29 and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis
(Effusion into Brain)
Stroke
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis
(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C B Grimes Jr, M. D.

19 (Address) 26 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 20, 1929

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS W. B. Mitchell

Important. See instructions on back

Spec.—2-29-28—L. F. S.—500 Bks.

E 51122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 51122

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 207 Club Road ST. 27-53 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert C. Tolson

(a) RESIDENCE NO. 207 Club Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 Years yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Klinefelter

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Att'y at law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent County
(State or country) Md.

PARENTS

10 NAME OF FATHER J. C. Tolson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ettie Ringgold

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14

Informant Mrs. Ella K. Tolson
(Address) 207 Club Road

15

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Nov. 17, 1929, that I last saw him alive on Nov. 17, 1929 and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis. (Nov 15.)
(Second attack) Nov. 17 -

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. Days.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

Nov 17, 1929 (Address) 4 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Nov. 20, 1929

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Pl.

M. P. Mitchell

Important: See instructions on reverse side.

Spec.—2-29-23—L. F. S.—500 Bks.

E 51123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2728 Pennsylvania ave. ST. 15-59 WARD)

2—FULL NAME Harry G. Whettle

(a) RESIDENCE NO. 2728 Pa. ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occ Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Whettle

6 DATE OF BIRTH (month, day, and year) Aug 30. 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Whettle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Hutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Wm. Whettle (Father)

(Address) 2918 Clifton ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9th, 1929, to Nov. 18th, 1929, that I last saw h alive on Nov. 6th, 1929, and that death occurred, on the date stated above, at 5 00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Ethel C. Reitzel M. D.

11/19, 1929 (Address) 2227 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Nov. 21 1929

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St.

Important

1 G 1929

THOMPSON-JONES M

Spec.—2-29-28—L. F. S.—500 Bks.

23/190 E 51124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 ✓ E 51124

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina Pollett

(a) RESIDENCE NO. 1622 N. Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew

6 DATE OF BIRTH (month, day, and year) 4-16-93

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm Hansel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Helena Sauerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-19-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 19, 1929, that I last saw her alive on Nov 19, 1929 and that death occurred, on the date stated above, at 1201 A m.

The CAUSE OF DEATH* was as follows:

Scarlet fever. Anuria. Nephritis 6 ds

about two days duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia Pneumonia Bronchio bilateral

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hamlet R Smith Jr, M. D.

, 19 (Address) 927 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a/c	11-20 1929
20 UNDERTAKER	ADDRESS
Bernard C Harke	1400 S Paca St

NOV 29 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51125

CERTIFICATE OF DEATH

109-002 E 51125

1—PLACE OF DEATH Balto. City Hosp.

REGISTERED NO. 7331

CITY OF BALTIMORE: (No. ..... ST. ..... WARD):

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Coleman Grundby

(a) RESIDENCE NO. 911 S. Sharp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Est. 20 - 24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Taby ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ..... 19 ..... C. HARPER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929 to Nov. 16, 1929

that I last saw her alive on Nov. 16, 1929

and that death occurred, on the date stated above, at 12:30 PM

The CAUSE OF DEATH* was as follows:

Vincents Angina

(duration) ..... yrs. ..... mos. 2/ ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Conrad Acton, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Nov 20 1929
20 UNDERTAKER John H. Trautman	ADDRESS 1027 Edmondson Ave

Important: Do not write above this line.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51126

CERTIFICATE OF DEATH

90 E 51126

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1440 Carroll St.) 21-28 Ward

2-FULL NAME Eleanora Smith

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1440 Carroll St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 6 1871

7 AGE — Years: 58 Months: 6 Days: 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): md

PARENTS

10 NAME OF FATHER: Louis deal

11 BIRTHPLACE OF FATHER (City or town): md

(State or country): Lorah castor

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): md

(State or country)

14 Informant: Roberta Brown

(Address) 1440 Carroll St

15 Filed NOV 20 1929 H. Jackson JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd 1929 to Nov. 16 1929

that I last saw her alive on Nov. 15 1929

and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Meadowcroft M. D.

11/18 1929 (Address) 1423 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: Nov. 20 1929

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Hull

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51127

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51127

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 Madison Ave ST.) (WARD 59)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Handy

(a) RESIDENCE NO. 2221 Madison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Handy

6 DATE OF BIRTH (month, day, and year): Dec. 29-1862

7 AGE — Years: 66 | Months: 10 | Days: 18 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John W. Handy

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Jane

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md

14 Informant: Clara P. Handy

(Address) 2221 Madison Ave

15 Filed NOV 28 1929 19 Registrar

CAMPBELL JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17-29

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1927, to Nov. 17-, 1929, that I last saw him alive on Nov. 16-, 1929, and that death occurred, on the date stated above, at 12-20 M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation, Caused by Mitral Insufficiency, Hypertrophy, Arterio-Sclerosis - Hypostatic Congestion (my knowledge)

(duration) 2 yrs. 7 mos. 14 ds.

CONTRIBUTORY (Secondary): 8 months

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam.

(Signed) J. Edward Mayer, M. D.

Nov 19 19 29 (Address) 212 S Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov 20 29

20 UNDERTAKER: Samuel Brooks — ADDRESS: Baltimore

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51128

CERTIFICATE OF DEATH.

100-001

E 51128

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Gholson

(a) RESIDENCE NO. 1511 E. Fayette St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Gholson

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) V.a

PARENTS

10 NAME OF FATHER Richard Gholson

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) V.a

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) unknown

14 Informant Jennie Gholson

(Address) 1511 E. Fayette St.

15 Filed ..... 19.....

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 18 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va Nov 20 1929

Date of Burial

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

very important. See instructions on back

Spec.—1-12-23—M&T—500 Blks.

E 51129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 51129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Kaufmann

(a) RESIDENCE NO. 1811 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Kaufmann

6 DATE OF BIRTH (month, day, and year) Nov 8 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68	68	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John C. Kaufmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agatha Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary J. Kaufmann

(Address) 1811 Mosher St.

15 Filed NOV 26 1929 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18 1929

I HEREBY CERTIFY, That I attended deceased from 8-14, 1929, to 11-18, 1929.

that I last saw h alive on 11-18, 1929

and that death occurred, on the date stated above, at 9.30 p m

The CAUSE OF DEATH* was as follows:

Chronic myocarditis (carcinoma of prostate)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 9-5-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov 22 1929

20 UNDERTAKER Henry Hoen's Sons, Inc.

ADDRESS 1307 E Eager St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51130 — CERTIFICATE OF DEATH — 117 — E 51130

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Mass Hosp ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amanda Bagnall

(a) RESIDENCE NO. 1932 Edmondson Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert D. Bagnall

6 DATE OF BIRTH (month, day, and year) Mar. 28-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Miss Bagnall

(Address) 1932 Edmondson Ave

15 Filed NOV 20 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 19, 1929, that I last saw h[illegible] alive on Nov 19, 1929 and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute gangrenous appendicitis, perforated

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation c[illegible] (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 11/13/29

Was there an autopsy? no

What test confirmed diagnosis? Operation & Clinical

(Signed) Henry F. Ulrich, M. D.

, 19 (Address) Hynnsky Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem — DATE OF BURIAL 11/22 19 29

UNDERTAKER Wm. J. Tickner & Sons — ADDRESS N. Y. Pa

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51131

CERTIFICATE OF DEATH

74-001

E 51131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: Fall Bonnie Hill & Wolfe St. 22 Ward)

2-FULL NAME Wm Jenifer

(a) RESIDENCE No. 1040 N. Stricker St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella

6 DATE OF BIRTH (month, day and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ft Mayo Va
(State or country)

PARENTS

10 NAME OF FATHER John Jenifer

11 BIRTHPLACE OF FATHER (city or town) Ft Mayo Va.
(State or country)

12 MAIDEN NAME OF MOTHER Estella Jenifer

13 BIRTHPLACE OF MOTHER (city or town) Ft Mayo Va
(State or country)

14 Informant Estella Jenifer
(Address) 1040 Stricker St

15 Filed ..... 19 H. LAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy)
(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fall Bonnie Hill & Wolfe St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) H. Lampson Jones, M. D.

Nov. 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Nov 21 1929
20 UNDERTAKER Thomas E. Kelly	ADDRESS 1303 Presstman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51132

CERTIFICATE OF DEATH

E 51132

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1519 Penna ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Davis

(a) RESIDENCE NO. 1519 Penna ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adline Davis

6 DATE OF BIRTH (month, day, and year): April 6 1876

7 AGE — Years: 53 | Months: 7 | Days: 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Oliver Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Beni O. Davis

(Address): 1519 Penna.

15 Filed 12-3 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4. 1929. to Nov 18. 1929. that I last saw h[illegible] alive on Nov 18. 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Woodridge, M. D.

11-19 1929 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Nov 21 1929

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 383 Pressman St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 51133

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Marlborough Apts. 7A. ST. 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Weil

(a) RESIDENCE NO. Marlborough Apts. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Weil

6 DATE OF BIRTH (month, day, and year) Jany. 9th. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wolf Katzenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Sacks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Weil

(Address) Marlborough Apts.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924. to Nov. 18, 1929.

that I last saw her alive on Nov. 18, 1929.

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows: Terminal Pneumonia - 2 days
Contrib. Myocarditis, Mitral Insufficiency
5 yrs or more

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hendley H. Morrison M. D.

. 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cheb Shalom Cem.

DATE OF BURIAL: 11/ 20/ 1929

20 UNDERTAKER Edward Sondheim

ADDRESS 118 20 W mt. Royal Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51134

1—PLACE OF DEATH

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. 2023 Eutaw Place. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Goldstein Loewenson

(a) RESIDENCE NO. 2023 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? 55 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Loewenson

6 DATE OF BIRTH (month, day, and year) May 20, 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER Bernard Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Hannah Bethelheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Rev. Geo. Castelle

(Address) 1911 Eutaw Place

15 Filed 12-0 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov 19, 1929, that I last saw h alive on Nov 19, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Frederic Lantz, M. D.

11-20, 1929 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	11/ 21/ 1929

20 UNDERTAKER Harry Sondheim

ADDRESS 118 20 W. Nat. Royal Ave

Spec.—1-12-23—M&T—500 Bks.

E 51135

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51135

CERTIFICATE OF DEATH.

90 V

1-PLACE OF DEATH Hebrew Aged Home.

CITY OF BALTIMORE: (No.) Lemdale ST. 27-54 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Berman

(a) RESIDENCE NO. Belvidere Ave. & Evergreen Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Her Bird Berman

6 DATE OF BIRTH (month, day, and year) Sept —.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 Filed Nov 21 1929, 19 at

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Nov, 1929, that I last saw h alive on Nov 19, 1929, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease.

(duration) — yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac asthma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A L Weistam, M. D.

, 19 (Address) 330 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Rosedale	11-20- 1929

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E Baltimore St

TION is very important See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Anthony Matthews (or) Matusewitz

E 51136 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Colverton Heights) (WARD) 29 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Matthews MATUSEWITZ

(a) RESIDENCE NO. 2313 Colverton Heights WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Matthews Matusewitz

6 DATE OF BIRTH (month, day, and year) June 14 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuanian

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Catherine Matthews Matusewitz (Address) 2313 Colverton Heights

15 Filed 20 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19. 1929

17

I HEREBY CERTIFY, That I attended deceased from June 1 1929 to Nov 18 1929.

that I last saw h— alive on Nov 18 1929,

and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Coarctation - Cachexia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carlos A Fehrenbach, M. D.

, 19 (Address) 806 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer DATE OF BURIAL Nov. 21 1929

20 UNDERTAKER Josiah Syfer ADDRESS 1600 W. Pratt

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—10

E 51137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51137

1-PLACE OF DEATH

City of Baltimore: (No. 108 N. Cross St. 23-31 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Thelma Freeman.(O)

(a) RESIDENCE NO. 108 N. Cross St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 15 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 5, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	0	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Lloyd Barnes.(O)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 NAME OF MOTHER Emma Freeman.(O)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Emma Freeman.(O) mother
(Address) 108 N. Cross St.

15 Filed ..., 19.. WILSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Eisenard, M. D.

11/20 1929 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL 11/20/29

20 UNDERTAKER Walter B. Sparks — ADDRESS 137 W Hamburg

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—1,. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51138

CERTIFICATE OF DEATH

90 E 51138

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2114 E. Biddle ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Ziegler

(a) RESIDENCE NO. 2114 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph. Ziegler

6 DATE OF BIRTH (month, day, and year) 6-21-1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Unknown Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adolph Ziegler

(Address) 2114 E. Biddle St.

15 Filed (1) H. HANSON JONES, M. D. Registrar

20 1029 PET

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Nov 20, 1929, that I last saw h alive on Nov 20, 1929 and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Olan Bruce, M. D.

11/20, 1929 (Address) 4202 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	11-23 1929
20 UNDERTAKER E. J. Rusch	ADDRESS Fifth Ave City

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51139

CERTIFICATE OF DEATH

198 ✓ E 51139

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Epps.(O)

(a) RESIDENCE NO. 914 S. Sharp St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed or divorced, HUSBAND of Alice Epps.(O)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Edward Epps.(O)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Emily Branch(O)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Alice Epps.(O) (wife)
(Address) 914 S. Sharp St.

15 Filed 11 20 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17th. 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia due to head injuries. Struck on the head with an axe. Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 802 Hanover St.
Did an operation precede death? Yes. Date of 11/10/29
Was there an autopsy? Yes.
What tests confirmed diagnosis? Autopsy & inquiry
(Signed) Otto M. Reinhardt M. D.
11/19 1929 (Address) 10[illegible] E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Black Stone. Va.	11-20 1929
20 UNDERTAKER Hunt Corbin	ADDRESS 816 E. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51140

CERTIFICATE OF DEATH.

45 E 51140

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 25-W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Amon Rigga

(a) RESIDENCE NO. 119 W. Fourth St ST., Frederick Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna

6 DATE OF BIRTH (month, day, and year): Jan 30 1866

7 AGE: Years 63 Months 9 Days 20. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad Fireman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Plummer Riggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Saylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Anna Rigga (Address) 119 W 4th St Frederick Md

15 Filed 12 1929 10 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-20 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-22, 1928, to 11-20, 1929 that I last saw him alive on 11-20, 1929 and that death occurred, on the date stated above, at 10.10 m

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum (inoperable to remove)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) involvement of liver

Carcinoma (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Frederick Md

Did an operation precede death? Yes Date of 11-23-28

Was there an autopsy? no (12-4-28

What test confirmed diagnosis? Direct observation

(Signed) Kinnaird H. Nicholas, M. D.

11/20 1929 Address) 704 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick, Md.

DATE OF BURIAL: Nov. 19 29

UNDERTAKER: Joseph B Cook

ADDRESS 1003 West Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51141

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary St. 8-17 WARD) 118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Vesely

(a) RESIDENCE NO. 1538 North Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White Bohemian	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles Vesely

6 DATE OF BIRTH (month, day, and year) May 12, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	53	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Geo Korecky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Son

(Address) 1538 North Gay Street

15 Filed NOV 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21 1929

17 I HEREBY CERTIFY, That I attended deceased from November 14, 1929, to November 17, 1929, that I last saw her alive on November 19, 1929, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of November 15 1929

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Emma C. Wallace M. D.

Nov. 19 1929 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre — DATE OF BURIAL Nov 22 1929

20 UNDERTAKER Fred Lauchheimer & Son — ADDRESS 1436 Eastern Ave

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

001 ✓

37 E 51142

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 N Fayette ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph G Serio

(a) RESIDENCE NO. 1525 N Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18, 90

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	39	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Salvatore Serio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Serio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14

Informant Frank Serio

(Address) 1525 N Fayette St

15

Nov 20 1929 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 29

17

I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 18, 1929, that I last saw him alive on Nov 17, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Miliary Tuberculosis

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Fran Riordan, M. D.

Nov 19 1929 (Address) 1031 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov 20 1929

20 UNDERTAKER: W M Routson — ADDRESS: 2258 N Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 51143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51143

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4708 Greenmount Ave ST., 27-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Lindsay Atkinson

(a) RESIDENCE NO. 4708 Greenmount Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Atkinson

6 DATE OF BIRTH (month, day, and year) Dec. 1st, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
~~67~~ 66	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Forge Dept.

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry & Mach. Shop

(c) Name of employer Bartlett-Hayward Co.

9 BIRTHPLACE (city or town) (State or country) Alexandria, Va.

PARENTS

10 NAME OF FATHER James W. Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria, Va.

12 MAIDEN NAME OF MOTHER Mary Hoye

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14

Informant James W. Atkinson

(Address) 201 N. Monroe St.

15 Dec. 2 0 1929, 19 H. LAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 19 29, to Nov 19, 19 29, that I last saw h[e] alive on Nov 19, 19 29, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chr. Ind Nephritis.
Chr. Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. N. Bishop, M. D.

Nov. 19 29 (Address) 501 Sheridan Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 11-22- 1929

20 UNDERTAKER: C. Vernon Lemmon

C. Vernon Lemmon

ADDRESS: 4513 Pk. Heights Ave.

Spec.—1-12-23—M&T—500 Blks.

E 51144 HEALTH DEPARTMENT—CITY OF BALTIMORE

100,001 E 51144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Mrs. Howard B. Harmon

(a) RESIDENCE NO. 1526 McKean Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice L Harman

6 DATE OF BIRTH (month, day, and year): July 20 - 1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
42	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): Auto

(c) Name of employer: Talbot Motor Co.

9 BIRTHPLACE (city or town) (State or country): Phila Pa

PARENTS

10 NAME OF FATHER: Wm H Harriman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Victoria Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Alice L Harman

(Address) 1526 McKean Ave

15 Filed 2 0 1929 C. HAMPSON JONES, M. D. Registrar

Per OKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1929. to Nov. 19 1929.

that I last saw h~~im~~ alive on Nov. 19 1929

and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:*

Broncho-pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pulmonary edema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Alessi M. D.

, 19 (Address) West Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 22nd 29

20 UNDERTAKER: Bertram & Joe — ADDRESS: 1723 W Lafayette Ave

THIS IS VERY IMPORTANT. See instructions on reverse side.

Spec.—2-29-28—L. F. S.—500 Bks.

23 E 302 51145

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51145

CERTIFICATE OF DEATH

9

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 6-1D WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida - E. Miles

(a) RESIDENCE NO. 127 N. Madeira ST., St — WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept-6-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) NONE

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Alex. Miles

11 BIRTHPLACE OF FATHER (city or town) Ga —
(State or country)

12 MAIDEN NAME OF MOTHER Cora Blanton

13 BIRTHPLACE OF MOTHER (city or town) Ga —
(State or country)

14 Informant Friends —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 20 1929, 19 C. HAMPSON JONES, M. D. Registrar
4087

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 18, 1929, that I last saw h. alive on Nov 18, 1929 and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

Pertussis pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Phys Exam.

(Signed) J. W. Buckford Jr, M. D.

11/19, 1929 (Address) H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS NOV 20 1929

Spec.—1-10-21—M&T—1500 Bks.

Simpson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51146

CERTIFICATE OF DEATH.

161-09

E 51146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital 10-14 ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Simpson

(a) RESIDENCE No. 1316 E. Madison St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1929

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
		one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) ND

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Ardealy Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant L. G. Douglas
(Address) Johns Hopkins Hospital

15 NOV 20 1929 C. HAMPSON JONES, M. D. Registrar
4085 now

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1929

17 I HEREBY CERTIFY, That I attended deceased from 11 14 1929 to 11 15 1929 that I last saw h[illegible] alive on 11 15 1929 and that death occurred, on the date stated above, at 12.25 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) L. G. Douglas M. D.

..... 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner

ADDRESS NOV 20 1929

CAUSE OF DEATH TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51147

CERTIFICATE OF DEATH

47 E 51147

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 330 E. 25th St. 12-5 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine G. Blatchley

(a) RESIDENCE NO. 330 E. 25th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Walter B. Blatchley

6 DATE OF BIRTH (month, day, and year) Nov 12- 1879

7 AGE — Years: 50 | Months: | Days: 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm B Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Roche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Jennie Blatchley

(Address) 330 E 25th St.

15 Filed C. HAMPSON JONES, M. D. Registrar

Dec 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1928, to April, 18, 1929, that I last saw her alive on Nov, 17, 1929 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis + Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. J. Zimmerman M.D.

11/18 1929 (Address) 2852 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mass Cathedral — DATE OF BURIAL Nov. 21, 1929

20 UNDERTAKER John A. Treon. — ADDRESS 3000 E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51148

CERTIFICATE OF DEATH

185 E 51148

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Franklin Sq. Hosp St., 10-28 Ward)

2-FULL NAME Charles E. Vinyard

(a) RESIDENCE NO. 2029 N Balto St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or)~~ WIFE of Emma Vinyard

6 DATE OF BIRTH (month, day, and year) May 5, 1861

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
68	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cattle Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER James Vinyard

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Louise Fuhs

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Emma Vinyard
(Address) 2029 N Balto Md

15 Filed 2-0-1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured skull Compound fracture right leg following fall from 3rd story window Franklin Hospital
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. A. Brogle M. D.
, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL May 24 1929

20 UNDERTAKER John Ullmt — ADDRESS 2008 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks. (Josephine Smyth)

E 51149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 12 4 V E 51149

1—PLACE OF DEATH

REGISTERED NO. 1929-44

CITY OF BALTIMORE: (No. Union Mem. Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Michael Smyth (Josephine)

(a) RESIDENCE NO. Green Spring Valley - Balto Co. md St., WARD 3 r.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Michael Smyth

6 DATE OF BIRTH (month, day, and year) Jan 15 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER William Woulson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Eleanor Costell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Husband.
(Address)

15 Filed NOV 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1929, to Nov 19, 1929, that I last saw h e r alive on Nov. 19, 1929, and that death occurred, on the date stated above, at 5:45 m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia + Ileus

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Green Spring Valley.

Did an operation precede death? Yes Date of Nov 18 1929
Removal of Gall Bladder

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination + symptoms.

(Signed) J. Sampson Jones, M. D.

, 19 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Charles Cem Pikesville. DATE OF BURIAL Nov 22 1929

UNDERTAKER Henry Menkin & Son ADDRESS Eutaw & Lexington Sts

Spec.—8-16-29—L. F. S.—100 Bks.

E 51150 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51150

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 N Chester St (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha King

(a) RESIDENCE NO. 1419 N Chester St WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard King

6 DATE OF BIRTH (month, day, and year) Dec 25-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant George Miller (Address) 1419 N Chester

15 Filed NOV 20 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19-1929

17 I HEREBY CERTIFY, That I attended deceased from October 25, 19 29, to Nov 19, 19 29, that I last saw h[er] alive on Nov 18, 19 29, and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis Hypertension

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual.

(Signed) Wm S. Leyer, M. D.

19 (Address) 1516 N. Wheeler Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Redemption

DATE OF BURIAL Nov 22 1929

20 UNDERTAKER M. & E. Hepplestone & Sons

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 5115I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-09 E 5115I

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Henry Brown

(a) RESIDENCE NO. Hope Chapel, Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 16-1906.

7 AGE: Years 23 | Months 7 | Days 2/4 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: B & O R.R.

9 BIRTHPLACE (city or town)
(State or country): Md.

PARENTS

10 NAME OF FATHER: Benj. Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Dugan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: John Harris
(Address): South River, Md.

15 Filed V 2 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Compound Fractures of Skull
Left Humerus, left femur
Struck by train (Accident, Suicide or Homicide)

CONTRIBUTORY (Secondary) Death

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Joppa, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Tilley, M. D.

11/20 1929. (Address) 273 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPE CHAPEL CEMETERY

DATE OF BURIAL: 11/22 1929

20 UNDERTAKER: Robert Brookerson

ADDRESS: Baltimore Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51152

CERTIFICATE OF DEATH.

32 E 51152

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Greenmillow St. 17-24 WARD)

2-FULL NAME Emmett Parker

(a) RESIDENCE NO. 524 Greenmillow ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Julia Parker

6 DATE OF BIRTH (month, day, and year) — — 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod carrier

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Surry Co Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " Va

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Va

14 Informant Hester Parker
(Address) 524 Greenmillow St

15 Filed NOV 21 1929 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1929 to Nov 19 1929, that I last saw him alive on Nov 14 1929, and that death occurred, on the date stated above, at 5a.m.

The CAUSE OF DEATH* was as follows:

1. Intramural myoma

(duration) yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Clark, M. D.

Nov 19, 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 21 1929

20 UNDERTAKER John H. Troadman — ADDRESS 1027 Hanover

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51153

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51153

135

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Prov'dent Hosp ST. 14-21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Matthews

(a) RESIDENCE NO. 1614 W Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Matthews

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 59 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Andrew Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E. Plumphrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Julia Matthews (Address) 1614 W Lexington

15 Filed NOV 21 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-20-1929

17 I HEREBY CERTIFY, That I attended deceased from 11-18-29 to 11-20-29

that I last saw h. alive on 11-20 19 29

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

Acute Urinary Retention (Hypertrophied Prostate)

Partial Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Obs.

(Signed) B Harris, M. D.

11/21, 19 29 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md - Antrim

DATE OF BURIAL: Nov 23 1929

20 UNDERTAKER: John H. Jordan

ADDRESS 1027 Hanover

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51154 — CERTIFICATE OF DEATH — 113 — E 51154

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thurston Buckingham

(a) RESIDENCE NO. Sykesville, Md ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
tt USBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23, 1929.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Sykesville, Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Buckingham

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lois Wolfe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 21 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Nov 20, 1929, that I last saw h.m alive on Nov 20, 1929 and that death occurred, on the date stated above, at 3 05 m.

The CAUSE OF DEATH* was as follows:

Chronic gastroenteritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) ohns media

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) B V Bickford Jr. M. D.

11/20, 1929 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Md	Nov 22 1929
20 UNDERTAKER	ADDRESS
Freer & Son Inc	Sykesville

Spec.—2-29-28—L. F. S.—500 Blks.

E 51155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 51155

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (T. B.)

CITY OF BALTIMORE: (No. ST., 14-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Capitola Lindamood

(a) RESIDENCE NO. 208 S. Carey st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Lindamood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed NOV 21 1929, HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1929, to Nov. 19, 1929,

that I last saw her alive on Nov. 19, 1929

and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jas Hernell, M. D.

11-20 1929 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov. 22 1929

20 UNDERTAKER Harry N. Twitchell, 1516 N. Stricker St. ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51156

CERTIFICATE OF DEATH

90 E 51156

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 - N. Gay St. ST., 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Noah Hoxter

(a) RESIDENCE NO. 1225 - N. Gay St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Hoxter

6 DATE OF BIRTH (month, day, and year) 11/24/1861

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
67	11	24 20	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 50

(b) General nature of industry, business, or establishment in which employed (or employer) Coach Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Hoxter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Catherine Lockwood

(Address) 1225 - N Gay St

15 DATE 12 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5 1929 to Nov. 18 1929

that I last saw h— alive on Nov 17 1929

and that death occurred, on the date stated above, at 3-45 m.

The CAUSE OF DEATH* was as follows:

Cardio - Vascular Dis - Cardiac Hypertrophy etc -

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual —

(Signed) Frank C Bremer, M. D.

19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md. DATE OF BURIAL 11/21/29

20 UNDERTAKER George J. Puth ADDRESS 1735 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51157

CERTIFICATE OF DEATH.

46 E 51157

1-PLACE OF DEATH

REGISTERED NO. 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home and Infirmary ST. WARD)

2-FULL NAME Mrs. Minnie Breitschwerdt

(a) RESIDENCE NO. 1644 Chilton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (OR) WIFE of late Geo Breitschwerdt

6 DATE OF BIRTH (month, day, and year) Aug 21/62

7 AGE: Years 67 | Months 2 | Days 30 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Fehle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Christina

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mrs Louis Lauer (Address) 1644 Chilton St.

15 Filed NOV 21 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20 1929

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1929, to November 20, 1929, that I last saw her alive on November 20, 1929 and that death occurred, on the date stated above, at 6:00 A. m.

The CAUSE OF DEATH* was as follows:

1. Mitral insufficiency: cardiac failure 2. Nephritis, chronic, with hypertension 3. Cystitis, chronic.

Pulmonary Embolus r. & l. (duration) 10 (1,203.) yrs. mos. 1 ds. (?)

CONTRIBUTORY (Secondary) Tumor of abdomen type (Carcinoma of Ovary, 1 or 2 yrs.) unoperated. (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of November 19, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Orin B. Wallace, M. D.

Nov. 20, 1929 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk — DATE OF BURIAL: Nov 23, 29

UNDERTAKER: Ortlip, Henry — ADDRESS 2016 Orleans St.

TION IS VERY IMPORTANT. See instructions on back

Spec.—2-29-28—L. F. S.—500 Bks.

E 51158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 51158

1—PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 14-29

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty Lee Geary

(a) RESIDENCE NO. 1316 McHenry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm A Geary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Grace L Stallings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Grace L Geary

(Address) 1316 McHenry St

15 Filed DEC 2 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased from November 13, 1929, to November 20, 1929, that I last saw her alive on November 19, 1929, and that death occurred, on the date stated above, at 12:40 A m.

The CAUSE OF DEATH* was as follows:

Secondary Syphilis with emphysema of left chest following pneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia with emphysema of left chest (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 15, 1929

Was there an autopsy? No

What test confirmed diagnosis? Thoracentesis & Wassermann

(Signed) Dr B Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk — DATE OF BURIAL 11-22 1929

20 UNDERTAKER Bernard C Harlan — ADDRESS 1000 E Lexington St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X162 E 51159

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) South Balto Hosp ST., 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Daniel Boyer

(a) RESIDENCE NO. Severn, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 16 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
4 das.	0	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Severn Md

PARENTS

10 NAME OF FATHER John A Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Severn Md

12 MAIDEN NAME OF MOTHER Anna Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Born Glen Md

14 Informant Mrs John A. Boyer
(Address) Severn Md

15 Filed NOV 21 1929 HAWSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased from 11-20, 1929, to 11-20, 1929, that I last saw him alive on 11-20, 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(New born infant)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lukaitis, M. D.

, 19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clark Burying Ground	Nov 22 1929
20 UNDERTAKER U.A. Co. Via Auto.	ADDRESS
John F Denny	215 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51160

90 ✓ E 51160

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 1217 Hanover St. St., 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Truman McCleary.

(a) RESIDENCE NO. 1217 Hanover St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of Isabelle McCleary.

6 DATE OF BIRTH (month, day, and year) September 21, 1872

7 AGE

Years	Months	Days	IF LESS than 1 day hrs. or min.
57	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.

(State or country)

PARENTS

10 NAME OF FATHER John H. McCleary.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine Ward.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Isabelle McCleary. (wife)

(Address) 1217 Hanover St.

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leinhardt M. D.

11/20 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 23 1929

20 UNDERTAKER Wm Tuckner & Son

ADDRESS N. Y. Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-001 E 51161

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 685 Washington Blvd (ST.) (WARD) 29-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME. Kathryn R. Schulte

(a) RESIDENCE NO. 685 Washington Blvd (ST.)

(Usual place of abode) WARD

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of F. W. Schulte Jr

6 DATE OF BIRTH (month, day, and year) Mar. 31-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Louis Fleischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant F. W. Schulte Jr

(Address) 685 Wash Blvd

Filed NOV 21 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 27 1924 to Nov 18 1929

that I last saw h alive on Nov 18 1929

and that death occurred, on the date stated above, at 10 P M

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ophthalmic Goitre Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov 4/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M C Finnegan M. D.

11/20/29 (Address) 682 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 21 1929
UNDERTAKER Wm J. Tuckner Son	ADDRESS N. Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51162

CERTIFICATE OF DEATH

3/ E 51162

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George S. Morrison

(a) RESIDENCE NO. 1111 E. Pratt st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Morrison

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Jesse Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Hospital Records

(Address)

15 Filed NOV 21 1929 H. Harrison Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1929, to Nov. 17, 1929, that I last saw him alive on Nov. 17, 1929 and that death occurred, on the date stated above, at 9.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Meningitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas Stinson M. D.

11-17-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 21 1929

Cor.—10-10-29—A Co.—100 Bks.

E 51163

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51163

CERTIFICATE OF DEATH

74001

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital, 14-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Hild.

(a) RESIDENCE NO. 1406 W. Baltimore Ste., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 7 mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divoreed, (write the word)
Male	White	Single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 17, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Anthony C. Hild.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Margaret McGarigal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Philadelphia, Pa.

14 Informant Ella K. Hild. (sisterinlaw)
(Address) 2824 Clifton Ave.

Filed NOV 21 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1406 W. Baltimore, Md

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Leonhardt, M. D.

11/20 1929 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peter's — DATE OF BURIAL 11/21 1929

20 UNDERTAKER John J. Fahey Son — ADDRESS 1918 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

231355 E 51164

CERTIFICATE OF DEATH

24 ✓ E 51164

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8-16 WARD)

2—FULL NAME Anna Maranto

(a) RESIDENCE NO. 1515 N. Luzerne ave ST., WARD 17 + 4
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-31-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Anna Grice

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 21 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-20-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 20, 1929, that I last saw her alive on Nov 20, 1929, and that death occurred, on the date stated above, at 8 37 P m.

The CAUSE OF DEATH* was as follows:

Meningitis — (meningococcus)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? spinal puncture

(Signed) J. M. Bickford Jr., M. D.

11/20, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL Nov 21, 1929

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

E 51165 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51165

CERTIFICATE OF DEATH.

99-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3609 Greenway St.; Superior 24 WARD) REGISTERED No. C

2-FULL NAME Cornelius M. Houck

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3609 Greenway St. Unk yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Write the word.) widowed

6-DATE OF BIRTH, Nov. 11, 1840
(Month) (Day) (Year)

7-AGE, 89 yrs. 9 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), M. Va

PARENTS.

10-NAME OF FATHER, M. Houck

11-BIRTHPLACE OF FATHER (State or Country), M. Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Houck Roberts

(Address) 3609 Greenway

15-

OCT 21 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1929
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1929, to Nov. 21 1929, that I saw h[illegible] alive on Nov. 20 1929, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis, sudden acute Heart Failure - Emphysema

6 days (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) 64 yrs. mos. ds.

(Signed) M. Gibson Foster M. D.

11/21, 1929. (Address) 1822 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park

DATE OF BURIAL, Nov. 22, 1929

20-UNDERTAKER Chas. Meyer & Son

ADDRESS Place

Cor.—10-10-29—A Co.—100 Bks.

E 51166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 ✓ E 51166

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Neal Lawrence

(a) RESIDENCE NO. 1002 W. Lawrence St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 hrs. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18/29

7 AGE	Years	Months	Days	IF LESS than 1 day 8 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Shumon Simms

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Neal.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Hopkins Record
(Address)

15 Filed 24 1929 16 C. HAMPSON JONES, M. D. Registrar

Dat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to he death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J S Phillips M. D.

11-21 1929 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bures Hill Cemetery

DATE OF BURIAL: Nov 22 1929

20 UNDERTAKER: Chas. E. Hicks Jr.

ADDRESS: 2447 Northwest Cemetery

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51167 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No.) Caution & Lwar ST. 8-17 45 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Lynch

(a) RESIDENCE NO. 1750 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeannette C. Lynch

6 DATE OF BIRTH (month, day, and year) Mch. 3. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	60	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Isaac Benesch & Son

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Lynch

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Sanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jeannette C. Lynch (Address) 1750 E. North Ave.

15 NOV 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1929, to Nov 21, 1929, that I last saw him alive on Nov. 20, 1929, and that death occurred, on the date stated above, at 6-05 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11/18/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. Messina, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery, DATE OF BURIAL: Nov. 23, 1929,

20 UNDERTAKER: Wm. C. Black ADDRESS: 927 N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51168

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51168

CERTIFICATE OF DEATH

REGISTERED NO. 47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2429 Westport ST. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Pensel

(a) RESIDENCE NO. 2429 Westport ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Pensel

6 DATE OF BIRTH (month, day, and year) Aug 27 186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Kirkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christian Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lola Degner

(Address) 2429 Westport Ave

15 Filed 2 1 1929 C. HAMPSON JONES, M. D. Registrar

By ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/29

17

I HEREBY CERTIFY, That I attended deceased from 9/10, 19 29, to 11/19, 19 29,

that I last saw her alive on 11/16, 19 29

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast.

Duration of tumor mass about 14 yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical exam.

(Signed) J. W. Grayton, M. D.

. 19 (Address) 2429 Westport Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/23 1929

20 UNDERTAKER S. J. Ruck

ADDRESS Upton Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51169

CERTIFICATE OF DEATH

124 E 51169

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2714 Boone St ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth McComas

(a) RESIDENCE NO. 2714 Boone St ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B. McComas

6 DATE OF BIRTH (month, day, year) 2/2/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER James Gosnell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) —

14 Informant Harry J. McComas

(Address) 2241 Montebello

15 Filed 21 1929 C. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) November 20th/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 19 29, to Nov 20th, 19 29, that I last saw her alive on Nov 19th, 19 29 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Calculous Cholecystitis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo. Montgomery Hill, M. D.

10/20/29 (Address) 401 E 25th St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/22 1929

20 UNDERTAKER Robert Brookerson — ADDRESS Baltimore Highlands

Cor.—10-10-29—A Co.—100 Bks.

E 51170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 ✓ E 51170

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 97-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Baby" Carter

(a) RESIDENCE NO. 630 Portland St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	S ingle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17/29

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie -----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Joseph Ahrens
(Address) 221 N Broadway

Filed 11 21 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Intestinal Disturbance (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Cox M. D.

11/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bengies Md — DATE OF BURIAL 10/21/29

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Broad

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation may be important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23 E 51171 — 49 — E 51171

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Beyer

(a) RESIDENCE NO. 516 N. Chapel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or Divorced. (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Chas Beyer

6 DATE OF BIRTH (month, day, and year): Jan 28th 1897

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Minnie Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 1 1929, C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 21 '29

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1929, to November 21, 1929, that I last saw her alive on November 21, 1929, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Cystic Glioma (malignant)

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/20/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) Harvey L. Gardner Jr., M. D.

11/21, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 24 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

E 51172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94-004 V E 51172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 679 W. Fayette St. 4-25 Ward)

2-FULL NAME John Lanham

(a) RESIDENCE NO. 679 W Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Lanham

6 DATE OF BIRTH (month, day, and year) Sept 1-1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler-makers
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R. R. Co

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Samuel Lanham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Amanda —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Lillie Lanham
(Address) Charlestown, W. Va

15 Filed 11 21 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillers, M. D.

11/21. 1929 (Address) 2732 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 11/26 1929

20 UNDERTAKER W. E. Cody — ADDRESS 1217 St Paul St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION AND important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bkn.

E 51173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001 ✓ E 51173

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2623 Hudson St. St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maryanna Sapliwa

(a) RESIDENCE NO. 2623 Hudson St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 14 1871

7 AGE: Years 58 Months 3 Days 6 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Rose Sapliwa

(Address) 2623 Hudson St.

15 Filed 21 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coal Poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (Duration) yrs. mos. ds.

(Signed) C. C. Slade M. D.

(Coroner)

, 19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. Date of Burial: Nov. 23 1929

20 UNDERTAKER: John M. Weber

ADDRESS: 401 E. Chase St.

OF DEATH in plain terms, as that a family physician may very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51174

CERTIFICATE OF DEATH

129 E 51174

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 521 E 25th St. ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward A Wiedefeld Sr

(a) RESIDENCE NO. 521 E 25th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida Gallagher

6 DATE OF BIRTH (month, day, and year) 7-17-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Francis H Wiedefeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Wiedefeld

(Address) 521 E 25th St

15 Filed C. HAMPSON JONES, M. D. Registrar

NOV 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 19 1929 to Nov 19 1929 that I last saw h live on Nov 18 1929 and that death occurred, on the date stated above, at 4:20 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Heart Disease

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F Conn M. D.

, 19 (Address) 4142 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Nov 22 1929

20 UNDERTAKER Vincent W Wiedefeld

ADDRESS 501 E 22nd St

Spec.—1-29-26—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51175

CERTIFICATE OF DEATH

9-100 E 51175

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3350 Chestnut Ave ST., (13-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura E Petticord

(a) RESIDENCE NO. 3350 Chestnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 2 - 1854

7 AGE: Years 75 | Months 5 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Weaver Cotton Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Witham B Petticord

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mr. Petticord

(Address) 3351 Chestnut Ave

15 Filed NOV 22 1929 19 G. HERBERT JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Nov 20, 1929, that I last saw her alive on Nov 20th, 1929 and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Senile Paresis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) Wm A Hiddleson M. D.

Nov 21. 1929 (Address) 550 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery DATE OF BURIAL: Nov 23 19 29

UNDERTAKER: W. Marshall ADDRESS: 3539 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51176

CERTIFICATE OF DEATH

24 to E 51176

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 N Glover St. WARD) 7-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Hanzlik

(a) RESIDENCE NO. 712 North Glover St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Hanzlik

6 DATE OF BIRTH (month, day, and year) May 20 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank Steiner

(Address) 712 N. Glover St.

15 Filed NOV 22 1929 HERMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Nov 21, 1929

that I last saw h[illegible] alive on Nov 21, 1929

and that death occurred, on the date stated above, at 12[15] P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William A Sauer M. D.

Nov 26 1929 (Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Nov 24 1929
20 UNDERTAKER	ADDRESS
August Pasek	2406 Ashland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 5177

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 51177

91-00

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 23-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas ~~McGuirk~~ McGURK

(a) RESIDENCE NO. 1024 Olive st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sells Pencils

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick McGuirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hosp.

15 Filed NOV 22 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Nov. 20, 1929, that I last saw him alive on Nov. 20, 1929 and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Colitis, chronic (unexplained)

(duration) over yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. & P.C.

(Signed) Marcia W. McLean, M. D.

11-21, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL 11-23 1929

20 UNDERTAKER E + B Harle 115 E West St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 31088
E 31178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51178

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., WARD 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Burrell

(a) RESIDENCE-NO. 1633 East Monument WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Burrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 12-2 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-20-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 20, 1929, that I last saw h[illegible] alive on Nov 20, 1929 and that death occurred, on the date stated above, at 5 55 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Carcinoma Esophagus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Hedwig Loewig, M. D.

11/21, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Nov 24 29

20 UNDERTAKER Samuel J Wensley ADDRESS 578 N Bridle

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51179

CERTIFICATE OF DEATH

182 E 51179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pier No.8 Locust Point. 18-7b Ward)

2-FULL NAME John Haynie.(C)

(a) RESIDENCE NO. 632 N.Carrollton Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 22nd.1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22	11	28 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Howard R.Haynie.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Jennie Hughlett.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant George E.Haynie.(C) uncle.
(Address) 632 N.Carrollton Ave.

15 Filed NOV 22 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Drowning.
Accidental fall from a scow.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

11/20 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lone Wk Northumberland Co Va	Nov 23 1929
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1450 N Mosher

OF DEATH in plain terms, so that it may be properly classified. Every question important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51180

CERTIFICATE OF DEATH.

1 86 103 E 51180

1-PLACE OF DEATH

City of BALTIMORE: No. Park Heights Ave & Dolfield Lane St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene K. Trumbo

(a) RESIDENCE NO. 4507 Pimlico Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Wm. H. Trumbo

6 DATE OF BIRTH (month, day, and year) Apr 4 - 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Chas. F. Hitesheu

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Newman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penn.

14 Informant Wm. Trumbo

(Address) Chicago Ill.

15 Filed 11 22 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Fracture Skull

Run down by auto while

Crossing road

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) J. J. Fran (Coroner) M. D.

11 21 1929 (Address) 5939 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? In front of 6011 Park Heights Ave

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem Nov 22 1929 Date of Burial

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS N. Wa

Very Important. See

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51181

CERTIFICATE OF DEATH

103

18 E 51181

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hosp St. 70-71 Ward

2-FULL NAME Jno Fred Mangler

(a) RESIDENCE NO. 107 Augusta Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Caroline Mangler

6 DATE OF BIRTH (month, day, and year) Oct 2 - 1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) Meat Business
(c) Name of employer self

9 BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER Geo M. Mangler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Beck

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant: Fred Mangler
(Address) 107 Augusta Ave

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Knocked down by motor
auto while walking on road

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Frederick Rd

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical

(Signed) J H Frame M. D.

11/21 19 29 (Address) 2939 Elm Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 11/22/1929

20 UNDERTAKER Jno Weber & Son — ADDRESS 2503 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Items are important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51182

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 22-30 ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Janie Smith

(a) RESIDENCE NO. 705 S. Green ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? — yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ? 07

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Va.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 NOV 22 1929 CLAMPITT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1929, to 11-20, 1929, that I last saw her alive on 11-20, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) ..... yrs. ..... mos. 40 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Interstitial (duration) ? yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C.

(Signed) Warren H. McLean, M. D.

11-20, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem

DATE OF BURIAL Nov. 23 1929

20 UNDERTAKER S. N. Brown & Son

ADDRESS 45 N. Dallas St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51183

CERTIFICATE OF DEATH

10-007

E 51183

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M. Reid

(a) RESIDENCE NO. 3154 Keswick Road St.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Ward

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas H. Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella M. Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elle M Reid

(Address) 3154 Keswick Road

15 Filed 22 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929, to Nov. 21, 1929, that I last saw h[illegible] alive on Nov. 21, 1929 and that death occurred, on the date stated above, at 10 05 P m.

The CAUSE OF DEATH* was as follows:

Tonsillar, Pharyngeal & Laryngeal Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of

Was there an autopsy? N D

What test confirmed diagnosis? Clinical

(Signed) Thyrsa G. Lee, M. D.

11/22, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	11/22/1929
20 UNDERTAKER	ADDRESS
J Walter Davis 3307	Pine St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51184

CERTIFICATE OF DEATH

1130

1—PLACE OF DEATH

REGISTERED NO. E 51184

CITY OF BALTIMORE: (No. 2212 Bank st. ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph. Zawadzki

(a) RESIDENCE NO. 2212 Bank st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 16/1929.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bolesław Zawadzki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Regina Kozuba

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Bolesław Zawadzki.

(Address) 2212 Bank st.

15 Filed 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22/29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929, to Nov 22, 1929, that I last saw h[illegible] alive on Nov. 20, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) A. F. Rus, M. D.

Nov 22, 1929 (Address) 24 O. Bmy

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Nov. 23 1929.
20 UNDERTAKER	ADDRESS
George A. Weber	705 S Amity st.

Spec.—1-12-23—M&T—500 Bks.

E 51185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-60 E 51185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 S Eastern Av St., WARD) 1

2-FULL NAME Adam Bogucki

(a) RESIDENCE NO. 1006 S Eastern St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 21 1929

7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Michael Bogucki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Lechowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Michael Bogucki 1006 S Eastern Av

DEC 2 1929

Filed .19 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 21 .19 29. to Nov 22 .19 29.

that I last saw h alive on Nov 22 1929.

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. William F. Hyland M. D.

19 Address 2012 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Standard Cem | DATE OF BURIAL Nov 22 1929

20 UNDERTAKER Stephen D Kalfas | ADDRESS 1000 S. Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 51186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00 E 51186

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3410 (Street) Devonshire Drive (WARD) 27-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Buhman.

(a) RESIDENCE. No. 3410 Devonshire Drive ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs 6 mos 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry C. Buhman

6 DATE OF BIRTH (month, day, and year): April 26, 1853

7 AGE — Years: 76 — Months: 6 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Germy

PARENTS

10 NAME OF FATHER: Henry Cliff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Caroline Schiedt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant (Address): Clifford Buhman 3410 Devonshire Drive

15 Filed NOV 22 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 20, 1929, that I last saw h[illegible] alive on Nov 20, 1929, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

La Grippe.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3410 Devonshire Dr.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 941 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov. 22 1929

20 UNDERTAKER: Eschmann — ADDRESS: 1025 Hanover

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51187

CERTIFICATE OF DEATH

601

11 E 51187

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 McCulloh ST., 13-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Mae Harris

(a) RESIDENCE NO. 2510 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew L. Harris

6 DATE OF BIRTH (month, day, and year) March 26-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33	32	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife & Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 69

(c) Name of employer Baltimore Public

9 BIRTHPLACE (city or town) (State or country) Halifax Va

PARENTS

10 NAME OF FATHER John Medley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elvira Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Halifax Va.

14 Informant Andrew L. Harris

(Address) 2510 McCulloh

15 Filed 12 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 19 29, to Nov 21, 19 29, that I last saw h alive on Nov 21, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Influenza a Bronchial type

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

11/21, 19 29 (Address) 1209 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Halifax Va.

DATE OF BURIAL 11-23 19 29

20 UNDERTAKER Chas. G. Cooper

ADDRESS 514 N. Eutaw St.

Spec.—1-12-23—M&T—500 Bks.

E 51188 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 215 N Madison ST. 11 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georga Winideck

(a) RESIDENCE NO. 215 W. Madison ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising Solicitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Oswald H Kritcher (Address) E. E Lexington St

15 Filed ..., 19 Registrar

H. JACKSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Nov 21, 1929, that I last saw him alive on Nov 21, 1929 and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) D Paul Miller, M. D.

11/22, 1929 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Nov 23 1929

20 UNDERTAKER John Ellerd

ADDRESS 2008 Orleans

TION is very important. See instructions on back

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51139

CERTIFICATE OF DEATH

× 10-001

E 51139

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 9-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Cannon

(a) RESIDENCE NO. Mt. Washington, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Non Resident yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nola Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nola Cannon

(Address) Mt. Washington Md

15 Filed NOV 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929, to Nov 21, 1929, that I last saw h[illegible] alive on Nov 21, 1929 and that death occurred, on the date stated above, at 1.20 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of Nov 21, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron S Tull, M. D.

11/22, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edwards Cem	Nov. 23 1929
20 UNDERTAKER	ADDRESS
Lex & Derr	1564 Ingleside ave.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51190

CERTIFICATE OF DEATH.

161-001

E 51190

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1802 ½ Dallas ST., (WARD) 8-1

2-FULL NAME Esp. Rodriguez

(a) RESIDENCE NO. 1802 ½ Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20. 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Un

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Rodriguez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna Koubek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) John Rodriguez 1802 ½ Dallas St

15 Filed NOV 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20 1929, to Nov 21 1929

that I last saw h alive on Nov 21 1929

and that death occurred, on the date stated above, at 1.15a m.

The CAUSE OF DEATH* was as follows:

Cremation Burn

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ry Sauer M. D.

Nov 21 1929 (Address) 80, N Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemy — DATE OF BURIAL Nov 22 1929

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford av

Spec.—2-29-28—L. F. S.—500 Blks.

51191

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

10 E 51191

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lafayette Cromwell

(a) RESIDENCE NO. 1202 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) Fla. (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Robert Simmons (Friend)
(Address) 1202 McCulloh St

15 Filed NOV 24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 20, 1929, that I last saw him alive on Nov 20, 1929, and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical & Laboratory

(Signed) Bernard Harris, M. D.

11-21-1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem	11-22-1929
20 UNDERTAKER	ADDRESS
Deems Eaton	Balto

Spec.—2-29-28—L. F. S.—500 Blks.

E 51192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 51192

1—PLACE OF DEATH Dallo City Hospt

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Thomas or Williams

(a) RESIDENCE NO. 831 W. Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 50 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) Dallo City Hosp ts.

15 Filed DEC 2 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19-29

17 I HEREBY CERTIFY, That I attended deceased from 11-10-, 19 29, to 11-19, 19 29

that I last saw her alive on 11-18, 19 29

and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Terminal Broncho Pneumonia

CONTRIBUTORY (Secondary) Psychosis a Cerebral Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. W. Drumm M. D.

11/20, 1929 (Address) Dallo City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 11-22-1929

20 UNDERTAKER: Dennis Easton

ADDRESS: Bel Air

Spec.—1-12-23—M&T—500 Bks.

E 51193 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51193

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 Penna. Ave St.) (Ward) 17-23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret A Lisby

(a) RESIDENCE NO. 748 Penna Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: Years 72 | Months — | Days — | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: Mrs Jos Hisbey (Address) 748 Penna ave

15 Filed [illegible], 19[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/21/1929

17

I HEREBY CERTIFY, That I attended deceased from 11/19/, 1929. to 11/21/, 1929.

that I last saw her alive on 11/21/29.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) J. V. Gadogna, M. D.

, 19 (Address) W. Baltimore & Hop.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 11-22-1929

20 UNDERTAKER: Daniel Easton — ADDRESS 946 Park ave

THIS IS VERY IMPORTANT — See instructions on reverse side

DEC 2 1929 HAMILTON, MD.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51194

CERTIFICATE OF DEATH

31

E 51194

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1728 Byrd ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W Hartlove

(a) RESIDENCE NO. 1728 Byrd ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 27 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Corby Hartlove

6 DATE OF BIRTH (month, day, and year) Aug 7 1904

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer N,E & S. Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank C Hartlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Hartlove (mother)

(Address) 1728 Byrd St

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Nov 22, 1929.

that I last saw him alive on Nov. 21, 1929

and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. N Campbell M. D.

Nov. 22 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Nov 26 1929

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St

Spec.—1-10-29-M&T—1500 Blks.

51195 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 E 51195

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. Mt. Sin. Hosp. ST., 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Stierhoff.

(a) RESIDENCE NO. 619 Plymouth Pl ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Hachtel

6 DATE OF BIRTH (month, day, and year): Jany 5. 1896

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
33	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manager 086
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant
(c) Name of employer: Western Elec. Co

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Fred. Stierhoff
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Magarete Emrich
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Nat. Records
(Address)

15 Filed NOV 22 1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-20 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-15 1929 to 11-19 1929, that I last saw him alive on 11-19-29, 19, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Paralytic ileus (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11-15-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas A Tompkins M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem
DATE OF BURIAL: Nov 23 1929

20 UNDERTAKER: Harry W. Ehlen
ADDRESS: 4044 W North Ave

CHECK OF CORRECTION. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51196

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N Bedford ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Gatonde

(a) RESIDENCE NO. 413 N Bedford ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Gatonde

6 DATE OF BIRTH (month, day, and year) 10 Nov 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Joseph Gatonde

(Address) 413 N Bedford

15 Filed 2-2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/29

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to Nov 20, 1929, that I last saw her alive on Nov 20, 1929, and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

CONTRIBUTORY (Secondary) (duration) yrs. 5 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William L. Rogers M. D.

11-24-29 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 23 1929

20 UNDERTAKER Frank Snowden — ADDRESS 1906 E Monument

Spec.—8-24-14—M. & T.—2000 Bks.

E 51197

HEALTH DEPARTMENT—CITY OF BALTIMORE

C 51197

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 S Caroline ST.; 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Koral

(Residence in Baltimore: No. 1400 S Caroline St.; 41 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: November (Month) 1 (Day) 1888 (Year)

7-AGE: 39 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Austria

PARENTS.

10-NAME OF FATHER: Nicholas Kural

11-BIRTHPLACE OF FATHER (State or Country): Austria

12-MAIDEN NAME OF MOTHER: Mary Kowan

13-BIRTHPLACE OF MOTHER (State or Country): Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas Koral

(Address) 1400 S. Caroline St

15-

Nov 22 1929, 191..... C. HAMPSON JONES, M. D.

Registrar. RFH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 22 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1929, to Nov 22 1929, that I saw h[illegible] alive on Nov 21 1929, and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis Chronic and Interstitial

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. K. Hartman M. D.

Nov 22, 1929 (Address) 1576 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Russum Woodlawn | DATE OF BURIAL, Nov 25 1929

20-UNDERTAKER McCandlish | ADDRESS 906 E Baltimore

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51198

CERTIFICATE OF DEATH

188-103 ✓ E 51198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2 West Batto Gru St., 146-67 Ward

2-FULL NAME Edwin M. Walker

(a) RESIDENCE NO. 3011 Pressman St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne C Walker

6 DATE OF BIRTH (month, day, and year) 2-27-1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	77	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance
(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Co
(c) Name of employer Home Mfg Co

9 BIRTHPLACE (city or town) Wash DC
(State or country)

PARENTS

10 NAME OF FATHER Jno H Walker

11 BIRTHPLACE OF FATHER (city or town) Wash DC
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Phillips

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Miss Catherine Walker
(Address) 3011 Pressman St.

22 1929 ..., 19 C. THOMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Knocked down by automobile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Concussion
Fract Clavicle (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Abermarle Road

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Frame M. D.

11/21 19 29 (Address) Byzig and Albany

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 23 19 29
20 UNDERTAKER	ADDRESS
Edmund M. Conklin	924 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51199

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2108 Hollins ST. 10-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Mc Quay

(a) RESIDENCE NO. 2108 Hollins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 5-1908

7 AGE: Years 21 | Months 8 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Mc Quay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Ida Butrim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

14 Informant: Wm Mc Quay

(Address) 2108 Hollins St

15 FILED 12 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21st

17 I HEREBY CERTIFY That I attended deceased from Nov 1, 1929, to Nov 20, 1929 that I last saw her alive on Nov 20, 1929 and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Heart Disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Nathan A Cof, M. D.

11/21, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Nov 23 1929

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51200

CERTIFICATE OF DEATH

185 E 51200

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Wickman

(a) RESIDENCE NO. 2508 Ailsa Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the George Wickman

6 DATE OF BIRTH (month, day, and year) Sept 23/55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	1	28 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Cress

11 BIRTHPLACE OF FATHER (city or town) Ger
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ger.

14 Informant Mrs. H. M. Diver

(Address) 2508 Ailsa ave

15 Filed 12 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20 192

17 I HEREBY CERTIFY, That I attended deceased from 3-9-29, 19..., to 11-20-1929, that I last saw her alive on 11-20-29, and that death occurred, on the date stated above, at 7 10 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis right arm

(duration) yrs. 9 mos.

CONTRIBUTORY (Secondary) Fracture femur → 2 mos.

Arteriosclerotic CV dis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

11/20/29 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Nov 23 1929

20 UNDERTAKER C. Philip Henry — ADDRESS 2016 Aisquith St

Spec.—1-10-21—M&T—1500 Bks.

E 5120I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003 E 5120I

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Monument & Lutton St.) WARD 26-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Fortuna

(a) RESIDENCE NO. 605 S. Lehigh Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Nov. 18. 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Fortuna

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Filomena Perrone

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant (Address) Father 605 S. Lehigh Av

Filed NOV 22 1929 ... 19 C. HAMPSON JONES, M. D. Registrar

Per ARB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-20 .1929. to 11-21 .1929.

that I last saw him alive on 11-21 .1929.

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) congenital

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B J Cohen M. D.

.19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Gunner Cemetery DATE OF BURIAL Nov. 22 1929

20 UNDERTAKER Wendell J Leppil ADDRESS 3001 Eden

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51202

CERTIFICATE OF DEATH

88 E 51202

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 606 S. Lakewood ave ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bridget Annie McDonald

(a) RESIDENCE NO. 606 S. Lakewood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of William McDonald

6 DATE OF BIRTH (month, day, and year) Jan 1855

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edw. Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Bleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Mary Moloney

(Address) 606 S. Lakewood Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 20, 1929, that I last saw her alive on Nov 19, 1929 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) ....yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

What there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) H. B. Tillotson, M. D.

Nov 21, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 23 1929

UNDERTAKER John A. Inman

ADDRESS [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51203

CERTIFICATE OF DEATH

129 E 51203

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 502 N. Linwood ave (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis J. Peters

(a) RESIDENCE NO. 502 N. Linwood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy E. Peters

6 DATE OF BIRTH (month, day, and year) Dec. 21-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	43	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumbing & Heating

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Joseph Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellicott City

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs. Peters

(Address) 502 N. Linwood ave

15 Filed DEC 2 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 19 29, to Nov. 21, 19 29 that I last saw h[illegible] alive on Nov. 21, 19 29 and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Embolism of coronary vessel

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Chronic Interstitial)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. (Physical)

(Signed) B O'Kelly M. D.

Nov 24, 1929 (Address) 100 N. Ludwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov. 25, 1929

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ Bishop Sheridan Ave 46 E 51204

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 Nicoll St., (WARD) 46

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie K. Brooks

(a) RESIDENCE NO. 508 Nicoll ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. J. Brooks

6 DATE OF BIRTH (month, day, and year) 1-23-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John N. Mahorney

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Laura A Dees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Benj J. Brooks

(Address) 508 Nicoll Ave

15 NOV 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Nov 20, 1929, that I last saw h... alive on Nov 20 1929 and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Metastasis in lungs, bladder

abdominal wall

(duration) 2+ yrs. mos. da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 1929

Was there an autopsy? No

What test confirmed diagnosis? Abdominal Incision - Specimen

(Signed) E. K. Brooks, M. D.

Nov 22, 1929 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 11/23 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

Spec.—1-10-21—M&T—1500 Bks.

E 51205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 51205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 13-59 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph De Luca

(a) RESIDENCE No. 3306 Auchentoroly Terrace (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose De Luca

6 DATE OF BIRTH (month, day, and year) Dec 2nd 1879

7 AGE Years	Months	Days	If LESS than 1 day,... hrs. or... min.
49	11	20 19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber Supply

(b) General nature of industry, business, or establishment in which employed (or employer) O & S

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph De Luca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rose De Luca

(Address) 3306 Auchentoroly Terrace

15 Filed 11 22 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/20/29, 19 . to 11/22/29, 19 . that I last saw him alive on 11/22/29, 19 , and that death occurred, on the date stated above at 4A, m.

The CAUSE OF DEATH* was as follows: empyema gall bladder

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 18 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/21/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A B Kinding, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 11/25 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51206 — CERTIFICATE OF DEATH. — 74-6 E 51206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital WARD 8-4D)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Thalheimer

(a) RESIDENCE No. 3126 Sawnview Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Geo H Thalheimer

6 DATE OF BIRTH (month, day, and year) July 27, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. J. Kohlhepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ditzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss A. Thalheimer (Address) 3126 Sawnview Ave

15 DATE RECEIVED 2 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Nov. 21, 1929, that I last saw h[illegible] alive on Nov. 21, 1929, and that death occurred, on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension (Arteriosclerosis)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Nov 25 1929

20 UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51207

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dominick Miskell

(a) RESIDENCE NO. 205 S. Collington ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? Unknown mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Veronica Miskell

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE — Years: 66 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Felice Miskell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Rosa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospital Records

(Address)

15 Filed 2 2 1929, 19 — C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929, to Nov. 22, 1929, that I last saw him alive on Nov. 22, 1929 and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Stemmer M. D.

11-22, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem Nov 25 | DATE OF BURIAL: 1929

20 UNDERTAKER: John M Weber & Sons | ADDRESS: Chester

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51208

90 E 51208

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2807 Chesterfield Ave St.) 8-45 (Ward)

2-FULL NAME Wilhelmina Herrman

(a) RESIDENCE NO. Elmont & Kenwood Aves St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Herrman

6 DATE OF BIRTH (month, day, and year) Oct 26/1848

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	81	0	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Edward Herrman
(Address) Elmont Ave., Raspburg

15 Filed 1929 H. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/22/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov. 25 1929

20 UNDERTAKER Frederick Lessalmo for Fridleton — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E.51209 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 51209

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 N. Montford Ave. 8-16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Mary Onesta

(a) RESIDENCE NO. 1804 N. Montford Ave ST. ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L. Onesta

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Andrew Shue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Emma Shue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Joseph L. Onesta (Husb)
(Address) 1864 N. Montford Ave

15 Filed 2 3 1929 C. HAMPSON JONES, M. D. Registrar By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-19-, 1929, to 11-20-, 1929, that I last saw her alive on 11-20-, 1929, and that death occurred, on the date stated above, at 8 18 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Hypertension

(duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Lyberk, M. D.

, 19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Clm — DATE OF BURIAL Nov 23 1929

20 UNDERTAKER Geo. E. Miller & Son — ADDRESS 2334 Jeffer

CAUSE OF DEATH in plain terms, so that any one may understand. TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Florence B. Souder

E 51210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 51210

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1435 E. Fort Ave. 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence B. Souder

(a) RESIDENCE NO. 1435 E. Fort Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph W. Souder

6 DATE OF BIRTH (month, day, and year): Nov. 17, 1892.

7 AGE: Years 37, Months Days 5. IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Charles Miller.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Leah Oldham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Ralph W. Souder.

(Address): 1432 E. Fort Ave.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Dec 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 11/29, 19..., to Nov 22/29, 19..., that I last saw her alive on Nov 21/29, 19..., and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos B Kolb, M. D.

Nov 22 29 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem Date of Burial: Nov 25 1929

20 UNDERTAKER: A. Leland Evans ADDRESS: 35 E Fort Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 5121

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5121

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2801 Huntington Ave. St. 17-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John D Magulas

(a) RESIDENCE NO. 2801 Huntington Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W Lite

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Magulas.

6 DATE OF BIRTH (month, day, and year): Feb 6. 1886

7 AGE: Years 44 (44) Months 9 Days 18 (17) IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Greece

PARENTS

10 NAME OF FATHER: John Magulas.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Greece

12 MAIDEN NAME OF MOTHER: Pandine Coronemis

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Greece

14 Informant: George Frantes

(Address) 2300 Annapolis Rd

15 Date: 11/23 1929 16 C. H. THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Pericardial Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Thompson M. D.

(Coroner)

11/22 1929 (Address) 3632 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Date of Burial 11/25 1929

20 UNDERTAKER: Margaret E. Tolyman ADDRESS 1422 Light St

OF DEATH in plain terms, so that it may be properly classified. Give statement of occupation as very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51212

1—PLACE OF DEATH

REGISTERED NO. 74-08

CITY OF BALTIMORE: (No. 1413. Hull. St. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William. J. Ferguson.

(a) RESIDENCE NO. 1413. Hull. St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if foreign birth 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget. O'Hara.

6 DATE OF BIRTH (month, day, and year) May. 17. 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Rail Road. Work

(c) Name of employer Balto. Ohio. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Maland

PARENTS

10 NAME OF FATHER James. Ferguson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irland

12 MAIDEN NAME OF MOTHER Bridget. O'Hara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maland

11 Informant Mrs Bridget Ferguson.

(Address) 1413 Hall St

15 Filed 2 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 19 29, to Nov 21, 19 29, that I last saw h alive on Nov 21, 19 29 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 1337 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 25 1929
20 UNDERTAKER Chas L. Stevens	ADDRESS 1501 E Fort Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 129 ✓ E 51213

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna M. O'Brien

(a) RESIDENCE NO. 2 Holmhurst Ave., Catonsville WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward B. O'Brien

6 DATE OF BIRTH (month, day, and year) July 15, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert L. Tillett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Carrie Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr. Edward B. O'Brien

(Address) 2 Holmhurst Ave., Catonsville

15 Filed 2 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased (from) July 1, 1929, to Nov. 20, 1929, that I last saw h er alive on Nov 20, 1929, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension
Myocarditis
Chronic Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab findings

(Signed) James Postorel, M. D.

11/21/1929 (Address) 715 Frederick Rd Catons.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Catheral Cemetery

DATE OF BURIAL Nov. 23 1929

20 UNDERTAKER Joseph L. Cook

ADDRESS 1003 West Baltimore St

Spec.—1-12-23—M&T—500 Blks.

E 51214

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. [redacted] ST. 25-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice B Johnson

(a) RESIDENCE NO. Glenwood Ave & N. Edmondson Ave ST. Catonsville WARD

(Usual place of abode)

Length of residence in city or town where death occurred [redacted] yrs. mos. 11 ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Johnson

6 DATE OF BIRTH (month, day, and year) About Sept. 17, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER John Close

11 BIRTHPLACE OF FATHER (city or town) Hull (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Eve Borrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Thomas Johnson

(Address) Glenwood Ave., Catonsville

15 Filed 11/23 1929 C. HARRISON PURNELL, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10th 1929 to Nov. 21st 1929,

that I last saw her alive on Nov. 21st 1929

and that death occurred, on the date stated above, at 9.15 P. m

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Colon

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11-11-29

Was there an autopsy? no

What test confirmed diagnosis? Microscopic section

(Signed) Ernest Spencer Jr., M. D.

11/21 1929 (Address) St. Agnes Hospital. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 23 1929

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N. Eutaw

TION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 51215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 51215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 323 W. Baltimore St. 12-50 Ward)

2-FULL NAME George L. Wagner

(a) RESIDENCE NO. 2913 St. Paul Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Wagner

6 DATE OF BIRTH (month, day, and year) June 29, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Woolens

(b) General nature of indnstry, business, or establishment in which employed (or employer) 045

(c) Name of employer George L. Wagner &

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Wm. Wagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorthea Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. George Wagner

(Address) 2913 St. Paul St.

23 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

Co (duration) ....yrs. ....mos. ....ds.

(Signed) Eugene Feller, M. D. (Coroner)

11/21 19 29. (Address) 2739 Eastern Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial Nov.23 1929

20 UNDERTAKER Robt. S. Cook ADDRESS 1003 West Baltimore St.

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51216

CERTIFICATE OF DEATH

90 ✓ E 51216

1—PLACE OF DEATH

REGISTERED NO. 16-66

CITY OF BALTIMORE: (No. 4112 Edmondson Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Ruhl

(a) RESIDENCE NO. 4112 Edmondson Ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Ruhl

6 DATE OF BIRTH (month, day, and year) June 18, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Flour Merchent

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Ruhl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Maria

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Emma C. Ruhl
(Address) 4112 Edmondson Avenue

15 Filed 23 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1928, to Nov. 21, 1929, that I last saw him alive on Nov. 21, 1929, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and
Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Eugene L. Pessagno, M. D.

Nov. 22 1929 (Address) 5-14 Drury Lane

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Nov. 24 1929

20 UNDERTAKER Lee, Block

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51217 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 51217

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1004 Franklintown Road ST. 16 to 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Hupka

(a) RESIDENCE NO. 1004 Franklintown Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Hupka

6 DATE OF BIRTH (month, day, and year) July 2, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Wentzel Hupka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Marie E. Fountain
(Address) 1004 Franklintown Road

15 Filed 23 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to nov 21, 1929, that I last saw him alive on nov 19, 1929, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left Side

CONTRIBUTORY (Secondary) General Arterio Sclerosis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Obs & Exam.

(Signed) John A. Kuhn M. D.

11/22, 1929 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 23 1929

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 51218

1—PLACE OF DEATH

REGISTERED NO. 20-69

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Ochs

(a) RESIDENCE NO. 304 Stinson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 7 mos 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. 3rd 1879

6 DATE OF BIRTH (month, day, and year) Sept 2, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ogle Md

PARENTS

10 NAME OF FATHER Leo Odell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berlin Md

12 MAIDEN NAME OF MOTHER Barbara Lauck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Geo. Odell 304 Stinson St

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/21/29

17 I HEREBY CERTIFY, That I attended deceased from 10/16, 1929, to 11/21, 1929 that I last saw her alive on 11/21/29, 1929 and that death occurred, on the date stated above, at 11:05 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Appendicitis & Peritonitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/19/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical-Operative

(Signed) Luther E. Hale, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11/25, 1929
20 UNDERTAKER	ADDRESS
E. R. Hilgenhurst	850 W. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51219

90-E 51219

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO. 16-23

CITY OF BALTIMORE: (No. 1514 Division ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Palmer

(a) RESIDENCE NO. 1128 Mosher ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Palmer

6 DATE OF BIRTH (month, day, and year): Unknown Feb 8 1869

7 AGE: Years 59 | Months 7 | Days 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Beverly Lacy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Agnes Sydney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Elizabeth Washington

(Address) 1128 Mosher St.

15 Filed 2 3 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22-29

17 I HEREBY CERTIFY, That I attended deceased from 10-3-29, 19..., to Nov. 22, 19 29,

that I last saw h.e alive on Nov 22, 19 29,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-vascular Disease with Cardiac Decompensation

(duration) Undetermined

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) George Just Mitchell, M. D.

19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: South Boston, Va. DATE OF BURIAL: 11/29/1929

20 UNDERTAKER: Mr. Mrs. H. H. Holland ADDRESS: 1631 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

E 51220 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 | 3 E 51220

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital (ST.) 1-18 (WARD)

2-FULL NAME Baby Harrison Blair Hoggs.

(a) RESIDENCE NO. Kingsville Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23-1828

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	1	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kingsville Md.

PARENTS

10 NAME OF FATHER Harrison D. Hoggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Myrtle Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant (Address) Mrs. Myrtle Hoggs

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov. 23, 1929,

that I last saw h[illegible] alive on Nov. 23, 1929,

and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory.

(Signed) J. H. Hoggs, M. D.

, 19 (Address) West Baltimore. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kingsville Cem — Balto Co.

DATE OF BURIAL Nov. 28 1929

20 UNDERTAKER Clarence E. Arthur

ADDRESS York Rd

23 1929 C. HAMPSON JONES, M. D. Registrar

Mar [illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

E 51221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

904 E 51221

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 944 W. Lexington ST. 18-76 (WARD)

2—FULL NAME Albert Buettner

(a) RESIDENCE NO. 944 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Whit	Singl

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Buettner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Blackley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Barbara Bottiger

(Address) 944 W. Lexington St.

15 Filed ..., 19 ... Registrar

2 31929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Nov 20, 1929, that I last saw him alive on Nov 19, 1929 and that death occurred, on the date stated above, at 945 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis
Myocarditis

(duration) ... yrs. ... mos. 10 da.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ... yrs. ... mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding

(Signed) S. H. Wiseal, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 23 1929
20. UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

Spec.—1-12-23—M&T—500 Blks.

E 51222

HEALTH DEPARTMENT—CITY OF BALTIMORE

Hyland

CERTIFICATE OF DEATH.

73 E 51222

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2229 Guilford Ave. ST. 17-50 WARD)

2-FULL NAME Ella M. Hyland

(a) RESIDENCE No. 2229 Guilford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Hyland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant C. H. Duvall

(Address) 1817 N. Fulton Ave

15 Filed 2 3 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 21, 1929, that I last saw h[illegible] alive on Nov 21, 1929, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

I Progressive Muscular Atrophy (Bulbar Type)

From Infancy (duration) — yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Duvall, M. D.

11-22-1929 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov 25 1929

20 UNDERTAKER Mary M. Woodyard — ADDRESS 501 E 22nd

E 51223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

V100-801 E 51223

1-PLACE OF DEATH

City of BALTIMORE: (No. 550 Welcome St. 27-30 Ward)

REGISTERED NO.

2-FULL NAME Rosie Spence

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 550 Welcome St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jun 6 1907

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
22	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

10 NAME OF FATHER Elijah Spence

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Addie Spence

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Carolina

PARENTS

14 Informant Addie Spence

(Address) 550 Welcome St

Filed ..... 19 ..... Registrar

Per ..... Deputy Registrar

23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Nov 21, 1929, that I last saw her alive on Nov. 20, 1929, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronch-Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Lemmel, M. D.

11/21 1929 (Address) 820 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Date of Burial Nov 23 1929

20 UNDERTAKER R. L. Parham ADDRESS 1007 S. Howard St

Of DEATH in plain terms, very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51224

CERTIFICATE OF DEATH

88 E 51224

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 S. Highland ave ST., 16-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William G. Williams

(a) RESIDENCE NO. 1324 S. Highland ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 75 mos. ds. How long in U. S., if foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Williams

6 DATE OF BIRTH (month, day, and year) June 3-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Smelter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. C. & S. Co.

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Elizabeth Williams

(Address) 1324 S. Highland ave.

15 Filed 2 3 1929 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29 15, 1929, to Nov. 22, 1929, that I last saw him alive on Nov. 21st, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) — yrs. — mos. 24 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) David Jones, M. D.

11/ , 1929 (Address) 1011 S. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Nov 25 1929

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager st.

Spec.—1-10-21—M&T—1500 Blks.

E 51225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 51225

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4309 Powell Ave: (St.) 26-42 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Williams

(a) RESIDENCE NO. 4309 Powell Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 4 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles C. Williams

6 DATE OF BIRTH (month, day, and year): July 4 1861

7 AGE: Years 68 | Months 4 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wilhelm Herbold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helena Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles C. Williams

(Address) 4309 Powell Ave.

15 Filed 19 ... Registrar

C. HAMPSON JONES, M. D.

2 3 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22 1929

17

I HEREBY CERTIFY, That I attended deceased from ~~Sept.~~ Nov. 27, 1929, to Nov. 22, 1929, that I last saw her alive on Nov. 21, 1929, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis & Arteriosclerosis (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas. C. Zimmerman M. D.

Nov. 22. 1929 (Address) 2858 Hartford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Lawn — DATE OF BURIAL: Nov 24 1929

20 UNDERTAKER: L. W. Dill — ADDRESS: Frederick Ave.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 | V E 51226

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 637 Sterling ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorris Hall

(a) RESIDENCE NO. 637 Sterling ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE — Years: 15 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Chas C Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Georgia Looks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Chas C. Hall
(Address): 637 Sterling st

15 Filed: 2 3 1929, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 21 29

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to Nov 21, 1929, that I last saw h alive on Nov 20, 1929 and that death occurred, on the date stated above, at 9-30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 0 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Health Dept

(Signed) J. Edward Fisher, M. D.

Nov 24 1929 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. — DATE OF BURIAL: Nov. 24 1929

20 UNDERTAKER: Mrs J. G. Locke — ADDRESS: 1302 Gilmor

Spec.—2-29-28—L. F. S.—500 Bks.

E 51227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital — REGISTERED NO. 1579-003 E 51227

CITY OF BALTIMORE: (No. ____ ST., 4-7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elaine Woodberry

(a) RESIDENCE NO. Aberdeen, Md. ST., ____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. 2 mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 19 29

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David L. Woodberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Elizabeth White

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant David L. Woodberry (Address) Aberdeen Md

15 Filed ____, 19 ____ C. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23/29.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Nov. 23, 1929, that I last saw h[illegible] alive on Nov. 23, 1929, and that death occurred, on the date stated above, at 8:30 P.M. m.

The CAUSE OF DEATH* was as follows:

Congenital Pyloric Stenosis

(duration) ____ yrs. 2 mos. ____ ds.

CONTRIBUTORY (Secondary) Inanition

(duration) ____ yrs. ____ mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Oct. 19/29

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinically & Pyloroplasty

(Signed) Forbmuth, M. D.

19 (Address) 1 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 23 19 29
20 UNDERTAKER John J. Fahey Son	ADDRESS 1318 Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51228

CERTIFICATE OF DEATH + 47

1—PLACE OF DEATH Womans Hospital REGISTERED NO. 44-20

CITY OF BALTIMORE: (No. ..... ST., H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antoinette Gregory Makely

(a) RESIDENCE NO. Lenoir N. C. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 4 mos. 4 ds. How long in U. S., if foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Metrah Makely

6 DATE OF BIRTH (month, day, and year) July 14-1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Greensboro N. C.

PARENTS

10 NAME OF FATHER George Gregory

11 BIRTHPLACE OF FATHER (city or town) Greensboro (State or country) N. C.

12 MAIDEN NAME OF MOTHER Emily Mullen

13 BIRTHPLACE OF MOTHER (city or town) Hertford (State or country) N. C.

14 Informant Metrah Makely

(Address) Lenoir Route 1 N. C.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from November 1, 1929, to November 23, 1929, that I last saw h.e alive on November 23, 1929, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Lile P. Clemson, M. D.

11/23, 1929 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morganton N. C.	Nov 25 1929
20 UNDERTAKER Henry W Jenkins & Co	ADDRESS Oxford N. Carolina

Spec.—2-29-28—L. F. S.—500 Bks.

E 51229
230433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 51229

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 25-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Viola Cunningham

(a) RESIDENCE NO. 1734 Tate St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-24-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Clark Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23-29

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Nov 23, 1929, that I last saw her alive on Nov 23, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis (not dysentery)
Bilateral otitis media

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Prematurity - Congenital Debility

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Nov 27 19 29
20 UNDERTAKER	ADDRESS
Lee & Sutherland	N.W. Cor Mulberry

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51230

CERTIFICATE OF DEATH

57 ✓

E 51230

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Clifton Avenue ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry V. Duff

(a) RESIDENCE NO. 3011 Clifton Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Sindall

6 DATE OF BIRTH (month, day, and year) April 16, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maryland State Pilot

(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Maryland

PARENTS

10 NAME OF FATHER James Duff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ----- Capprice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Florence S. Duff

(Address) 3011 Clifton Avenue

15 Filed NOV 24 1929 C. HAMPSON JONES, Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1929 to Nov 21 1929 that I last saw h[illegible] alive on Nov. 21 1929 and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 1 mo. 12 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) John C. Blake, M. D.

, 19 (Address) 719 Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 11/25 19 29

UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

Spec.—2-29-28—L. F. S.—500 Blks.

E 51231 HEALTH DEPARTMENT—CITY OF BALTIMORE 100 100 E 51231

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 20-27

CITY OF BALTIMORE: (No. 28 N. Fulton Ave., ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel E. Duggan

(a) RESIDENCE NO. 28 N. Fulton Ave., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony J. Duggan

6 DATE OF BIRTH (month, day, and year) March 10,1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	12 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Patrick H.Lafferty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth R. Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia, Pa.

14 Informant Miss Agnes J. Duggan

(Address) 28 N. Fulton Ave.,

15 Filed 12 4 1929, 19 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23,1929

17

I HEREBY CERTIFY, That I attended deceased from November 18, 19 29 to November 22, 19 29.

that I last saw her alive on November 22, 19 29

and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Nevolaluce M. D.

11/23/29 (Address) 24. N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/ 19 29
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calv. 24.

Spec.—8-16-29—L. F. S.—100 Bks.

Bailey 2805 N Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51232

CERTIFICATE OF DEATH

24-001 E 51232

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2802 Guilford Ave ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry O. Schaninger

(a) RESIDENCE NO. 2802 Guilford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Adele Schaninger

6 DATE OF BIRTH (month, day, and year): Nov 10-1863

7 AGE — Years: 66 — Months: 0 — Days: 12 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Mfgr

(b) General nature of industry, business, or establishment in which employed (or employer): Self 017

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward Schaninger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Adele Schaninger

(Address): 2802 Guilford Ave

15 Filed NOV 24 1929 C. HAMPSON JONES Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to ——, 19....,

that I last saw him alive on Nov 22, 19 29

and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 4 hours

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry O. Bailey M. D.

Nov 24, 1929 (Address) 2805 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 11/25 19 29

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 51233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓ E 51233

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (or) WARD

REGISTERED NO. 5168

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs ~~Mary~~ ANNE K. MURRAY Murray

(a) RESIDENCE NO. 2105 (Usual place of abode) Baker ST. WARD

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael J. Murray

6 DATE OF BIRTH (month, day and year): Aug 9, 1888

7 AGE: Years 41 | Months 3 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Aquilla Fredericks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Talley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Hugh Carey

(Address) Delaware ave.

15 Filed NOV 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/24/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1929, to November 24, 1929, that I last saw her alive on November 23, 1929 and that death occurred, on the date stated above, at 3:40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix

(duration) 2 yrs. ? mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/25/29

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thos. E. Stacy, Jr. M. D.

. 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cem.

DATE OF BURIAL: Nov. 26 1929

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51234

CERTIFICATE OF DEATH

90 ✓

E 51234

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Kirwick Road) (13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margarit Sener

(a) RESIDENCE NO. 3206 Kirwick Road ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Sener.

6 DATE OF BIRTH (month, day, and year) July 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79.	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Robert Allen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Margaret Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laurence Sener

(Address) 2 Wilstead Ave Mt. Washington

15 11-24 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 23, 1929, that I last saw h[illegible] alive on Nov, 19..., and that death occurred, on the date stated above, at 8[illegible]45 a.m.

The CAUSE OF DEATH* was as follows:*

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. H. Jones, M. D.

11-23 1929 (Address) 800 W 38th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL Nov 25 1929

20 UNDERTAKER Edmonds Elson

ADDRESS 3615 Eastland

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51235 — 90 E 51235

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 40 Poultney St. St.) 23-33 (Ward)

2-FULL NAME Louisa Wiesner.

(a) RESIDENCE NO. 40 Poultney St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. da. How long in U. S., if of foreign birth? 76 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If [redacted] widowed, [redacted] (or) WIFE of John Wiesner.

6 DATE OF BIRTH (month, day, and year) March 20, 1847

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	82	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Michael Grenzer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Marie Lessner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Lillie M. Seward. (daughter)
(Address) 40 Poultney St.

15 Filed NOV 24 1929 C. HARRISON JONES, M. D. Registrar
Dat 12/6

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Reinhardt, M. D.

11/28 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 26 1929
20 UNDERTAKER	ADDRESS
Wm. J. Tuckner & Son	N. Pa Ave

OF DEATH in plain terms, so that it may be properly classified. Every question important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51236 — CERTIFICATE OF DEATH — 129 — E 51236

1—PLACE OF DEATH University Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. Md ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Green

(a) RESIDENCE NO. 1615 W. Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
mal	Colored	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Green

6 DATE OF BIRTH (month, day, and year) Sept 1 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	43	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Repairer

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer Calvert Co

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Emanuel Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret A. Green
(Address) 1615 W. Mulberry

15 Filed NOV 24 1929 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-29

17 I HEREBY CERTIFY, That I attended deceased from 11-7- 1929, to 11-22 1929, that I last saw him alive on 11-22-29, 19..., and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension Heart disease & nephritis, Syphilis, Syphilis, arteria sclerosis generalized.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ...yrs. mos 14 ds.

18 Where was disease contracted if not at place of death? In army 1918

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) W. F. Varney, M. D.

11-22 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive Calvert Co — DATE OF BURIAL Nov 25 1929

20 UNDERTAKER Jam's W. Chase & Son — ADDRESS 1401 Madison

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51237.

CERTIFICATE OF DEATH.

46 E 51237

REGISTERED NO.

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. 27-43 ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Mt Fray

(a) RESIDENCE NO. 424 Winston Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of John M. Fray

6 DATE OF BIRTH (month, day, and year) Aug 29, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Carson Schumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Hospital records

(Address)

15 Filed NOV 24 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/22, 1929, to 11/23, 1929, that I last saw her alive on 11/23, 1929, and that death occurred, on the date stated above, at 11 10 a.m.

The CAUSE OF DEATH* was as follows:

Mesenteric thrombosis

Diabetes Mellitus.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 11/22/29

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jno A Hampton, M. D.

11/24/29 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 19

20 UNDERTAKER Geo H Little

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51238

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Talbot Road ST. 28-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wallace G. Jackson,

(a) RESIDENCE NO. 2606 Talbot Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 2 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
Male	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) Sept. 4. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John S. Jackson,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary C. Pickering,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Miss Cecelia Jackson

(Address) 2606 Talbot Road

NOV 24 1929

Filed HUMPHREY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 23/29, 19..., to Nov 27/29, 19... one day

that I last saw h~~im~~ alive on Nov. 23/29, 19...

and that death occurred, on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

He was under my care 1 day—

Acute dilitation of Heart

CONTRIBUTORY (Secondary) Acute dilitation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Tiblett M. D.

Nov 24/29, 19... (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park DATE OF BURIAL 19...

20 UNDERTAKER Geo W Little ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

E 51239

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

90 E 51239

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3921 Maine Ave St. 15-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Wilson Knowles

(a) RESIDENCE NO. 3921 Maine Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Anna B Knowles

6 DATE OF BIRTH (month, day, and year): Aug 21, 1852

7 AGE: Years 77 Months 2 Days 23 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Wilson Knowles

11 BIRTHPLACE OF FATHER (City or town): Seaford

(State or country): Delaware

12 MAIDEN NAME OF MOTHER: Mary Ann Burgess

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Mrs. Anna B Knowles

(Address): 3921 Maine Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Nov 23, 1929, that I last saw h~~im~~ alive on Nov 23, 1929, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) A. C. Samuels, M. D.

(Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — Date of Burial: Nov. 26 1929

20 UNDERTAKER: John B. Spencer — ADDRESS: 1335 W. Carlton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 51239

NOV 24 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51240

CERTIFICATE OF DEATH

124 E 51240

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union memorial Hop ST. 28-21 WARD)

2—FULL NAME Mr. Thomas J. Boswell.

(a) RESIDENCE NO. 9 Frederick Rd & Homewood Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 0 mos. ✓ ds. ✓ How long in U. S., if foreign birth? 73 yrs. 1 mo 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Sarah E. Brown.

6 DATE OF BIRTH (month, day, and year) Oct 13, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pool operator.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER Wm. C. Boswell.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Sarah E Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Son (Edw. T. Boswell)
(Address) Catonsville

15 Filed 4 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929 to Nov. 23 1929, that I last saw him alive on Nov 22 1929. and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Gall Bladder - & Chronic Cholecystitis - Peritonitis

(duration) ....yrs. ....mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs ....mos. ....ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) L. K. Cunningham, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 25 19 29.
20 UNDERTAKER	ADDRESS
Stewart & Co	Dale.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51241 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 51241

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 S. Eden Street ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maddalena Mercurio

(a) RESIDENCE NO. 423 S. Eden Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincenzo Mercurio

6 DATE OF BIRTH (month, day, and year) April 9, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Donato Trevisonno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Thressa Pozzi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Giuseppe Mercurio
(Address) 423 S. Eden Street

15 Filed 2 4 1929 C. HUNSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21/29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929, to Nov. 21, 1929

that I last saw h er alive on Nov. 21, 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

Acute Myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Artigiani, M. D.

. 19 (Address) 2946 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 25 1929.

20 UNDERTAKER Geo. A. Ruth ADDRESS 1735 Fleet

Spec.—2-29-28—L. F. S.—500 Blks.

McGill

E 51242

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 51242

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 4-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Donald C McGill

(a) RESIDENCE NO. 1238 E North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorena V. McGill

6 DATE OF BIRTH (month, day, and year) Dec 23/1886.

7 AGE: 43 Years: 42 Months: 11 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lunch Room.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Washington. D C.

PARENTS

10 NAME OF FATHER: William McGill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington. D. C.

12 MAIDEN NAME OF MOTHER: Anna Dewitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Langdon Md

14 Informant: Mrs Lorena. McGill

(Address) 1238. E north Ave

15 Filed: NOV 24 1929 LAWRENCE JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-7-, 19 29, to 11-23-, 19 29,

that I last saw him alive on 11-23-, 19 29

and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

Several months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Louis P. Gundry, M. D.

11-23. 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov 26 1929

20 UNDERTAKER: Groves - Logsdon

ADDRESS: 1735 Harford ave.

Cor.—10-10-29—A Co.—100 Bks.

E 51243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-009 51243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1722 Holbrook St. 9-18 Ward)

2-FULL NAME William C. Murphy

(a) RESIDENCE NO. 1722 Holbrook St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B Murphy

6 DATE OF BIRTH (month, day, and year) Oct 8/1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	62	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer) A. S. Abell Co.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER B. E. Murphy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Dorsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs Anna B Murphy [redacted] 1722 Holbrook St.

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/24/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 15 1929
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

IF DEATH is plain terms, as that it may be properly classified. important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51244

CERTIFICATE OF DEATH.

89 E 51244

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of BALTIMORE: (No. Lakeland 1558 Park Heights Street S. 15 Ward)

2-FULL NAME Herman Blankman

(a) RESIDENCE NO. 2401 Parkside St. Ward
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Blankman

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. Lewis
(Address) 1439 E Balto. St

15 Filed ..... 19 ..... Registrar

V 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Thomson M. D.
(Coroner)
11 24 1929 (Address) 7332 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt. Carmel — Date of Burial: 11-24-1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

Very Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51245

CERTIFICATE OF DEATH

74-002

E 51245

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 517 S. Kenwood Ave ST., V 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Johanna H. Deegan

(a) RESIDENCE NO. 517 S. Kenwood Ave ST., 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Bernard Deegan

6 DATE OF BIRTH (month, day, and year) April 9th 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Martin Ford

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Ellen K. McEown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Francis Deegan
(Address) 517 S. Kenwood Ave

15 Filed 2-4 1929, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23rd/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929, to Nov. 23, 1929, that I last saw her alive on " 22, 1929 and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. Heller, M. D.

(Address) 408 E. Eager Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 26 1929
20 UNDERTAKER Lilly + Zeiler Inc.	ADDRESS 402 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51246

CERTIFICATE OF DEATH

129 E 51246

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S. Linwood St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa A. Stricklin

(a) RESIDENCE NO. 611 S. Linwood Ave St., 1 Ward
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 23 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Strickler

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Keller

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14

Informant Mrs. Helen Higgins

(Address) 611 S. Linwood Ave

15

Filed 12 4 1929, C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1929, to Nov. 21, 1929, that I last saw her alive on Nov. 20, 1929, and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 7 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmidt, M. D.

11/22, 1929 (Address) 701 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov. 25 1929
20 UNDERTAKER Lilly & Zeiler Bros.	ADDRESS 403 S. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

Yauzaitis

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51247

CERTIFICATE OF DEATH

24-001 E 51247

1-PLACE OF DEATH

City of Baltimore: (No. 1412 Ramsay St. 19-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Yuzaitis

(a) RESIDENCE NO. 1412 Ramsay St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No 1891

7 AGE	38 Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor
(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania
(State or country)

PARENTS

10 NAME OF FATHER Paul Yuzaitis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER K.Remeikis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Litvania

14 Informant K.Yuzaitis
(Address) 1412 Ramsay St.

15 Filed 19 C. HAWSON JONES M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

Nov 24, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 25. 1929
20 UNDERTAKER John Grebliauckas	ADDRESS 1421 S Pace St.

DEATH to be filled in plain terms, so that it may be properly understood. Every question important. See instructions on back of certificate.

Nov 25 1929

Reg. 1881

Cor.—10-10-29—A Co.—100 Bks.

E 51248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 51248

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 110 N. Grove St. 4-25 Ward)

2-FULL NAME Barbara Seukus

(a) RESIDENCE NO 110 N. Grove St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Seukus

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Athome
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Lithuania

14 Informant Elizabeth Unites
(Address) 110 N. Grove St

15 Filed 11/24 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller, M. D.

11/24 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 26. 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas & Co.	425 S Paca St

OF DEATH in plain terms, so that it may be properly classified. All questions must be answered if possible. Physicians are required to report the cause of death in accordance with the instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51249 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 51249

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert & Saratoga ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anton Mazelofsky

(a) RESIDENCE NO. 112 Albemarle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Litovania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant E. Mazelouskas
(Address) 112 Albemaul St.

15 Filed 24 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1929, to Nov. 23, 1929, that I last saw him alive on Nov. 22, 1929, and that death occurred, on the date stated above, at 5 40 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Nephritis (uremia)

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Sarah F. Guglia, M. D.

. 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislowas	Nov. 27 19 29

20 UNDERTAKER John Grebliauckas & Co. ADDRESS 423 S Paca St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. E 51250

CITY OF BALTIMORE: (No. ..... ST. 11-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Fellows

(a) RESIDENCE NO. 605 N. Calvert ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Lyle Fellows

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Naomi S. Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mercy Hospital Record

(Address) .....

15 Filed ..... 19 .....

C. HARRISON JONES, M. D. Registrar

2 FEB 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20, 1929.

17 I HEREBY CERTIFY, That I attended deceased from 10-14-, 1929, to 11-20, 1929, that I last saw her alive on 11-20, 1929 and that death occurred, on the date stated above, at 10 55 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

11/20 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL Nov 29

20 UNDERTAKER John J Fahey Sons — ADDRESS 1318 Light St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001 ✓

E 51251

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 William ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta M. Auer

(a) RESIDENCE NO. 1217 William ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/25/1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57 / 58	10 / 11	27 / 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Auer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ada Hasselberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs M Lindsay

(Address) 121 William St

15 Filed NOV 24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 22, 1929, that I last saw h alive on Nov 22, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 4 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. M. Selde M. D.

11/23, 1929 (Address) 1299 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL 11/25 1929

20 UNDERTAKER J J Doherty & Sons

ADDRESS 1318 Light St

Spec.—2-30-28—L. P. S.—600 Blks.

Chaney

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51252

CERTIFICATE OF DEATH

E 51252

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1225 Cleveland St. ST. 21-29 WARD)

2—FULL NAME Helen M. Chaney

(a) RESIDENCE NO. 1225 Cleveland St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Samuel L. Chaney

6 DATE OF BIRTH (month, day, and year) June 23,1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ethel L. Chaney

(Address) 1225 Cleveland St.

NOV 24 1929

E. H[illegible]SON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1929

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Nov 23, 1929, that I last saw h[illegible] alive on Nov 21, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Ryerson, M. D.

11/23 1929 (Address) 6 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov/27/19 29

20 UNDERTAKER Harry N. Leitz & Co. 1531 W. Lombard St.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51253 — CERTIFICATE OF DEATH — E 51253

1-PLACE OF DEATH

City of Baltimore: (No. 4013 Orchard St Brooklyn. St., 25-75 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel L. Clayland.

(a) RESIDENCE NO. 4013 Orchard St. Brooklyn. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If ~~married, widowed, or~~ HUSBAND of ~~XXXXXXXX~~ Emily Clayland

6 DATE OF BIRTH (month, day, and year) March 19, 1847

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	82	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel R. Clayland.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Maude Robinson, (daughter)
(Address) 4013 Orchard St. Brooklyn.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

12 4 1929 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto H. Feinandt, M. D.
11/23 1929 (Address) 1017 St. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Nov. 25 1929

20 UNDERTAKER Harry V. Luitke, 1531 ADDRESS Lombard

Please fill in all blanks, as they are very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51254

CERTIFICATE OF DEATH.

10 1-002

E 51254

REGISTERED NO. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 724 N. Hilton ST. 16-62 (WARD)

2-FULL NAME George Jenkes

(a) RESIDENCE NO. 724 N. Hilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mariah Jenkes Widower

6 DATE OF BIRTH (month, day, and year) 6. 24. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or min.
	85	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) Boonville (State or country) New York

PARENTS

10 NAME OF FATHER Wm Jenkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Carrie Cruikshanks (Address) 724 N. Hilton St.

15 Filed NOV 24 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov. 22, 1929, that I last saw h alive on Nov. 22, 1929, and that death occurred, on the date stated above, at 8.10 a m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Cerebro Sclerosis Senile Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) E. H. Becken, M. D.

11.23.1929 (Address) Fort Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loyal Wisconsin — DATE OF BURIAL Nov 24 1929

UNDERTAKER Harry N. Mutzke, 1531 N Lombard ADDRESS St.

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51255 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

36 E 51255

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 21-24 ST. WARD)

2—FULL NAME William Scanlon

(a) RESIDENCE NO. 1031 W. Cross ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass blower. 08

(b) General nature of industry, business, or establishment in which employed (or employer) Glass.

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Buffalo
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Records
(Address) Baltimore City Hospitals

15 Filed 2-4-1929 C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1924, to Nov 22, 1929, that I last saw him alive on Nov 22, 1929, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Syphilis of Central nervous System;

(duration) More than 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General exam. Wassermann.

(Signed) Warren H. McLean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Butler Pa.	Nov 25 1929

20 UNDERTAKER Harry A. Whitla, 153 W. ADDRESS Lombard 21

Spec.—1-12-23—M&T—500 Bks.

E 51256 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 74-001 51256

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Orleans ST. 5-9 WARD)

2-FULL NAME Susie Coleman.

(a) RESIDENCE NO. 1408 orleans. ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colord
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE — Years: 49 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House worker
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): V.a

PARENTS
10 NAME OF FATHER: Cindy Tuggle
11 BIRTHPLACE OF FATHER (city or town) (State or country): V.a
12 MAIDEN NAME OF MOTHER: Cryssella Brodey
13 BIRTHPLACE OF MOTHER (city or town) (State or country): V.a

14 Informant: Maria Coolman
(Address) 1408 orleans st.

15 Filed 12 4 1929 G. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-1929

17 I HEREBY CERTIFY, That I attended deceased from 11-16-, 1929, to 11-22-, 1929, that I last saw ~~him~~ alive on 11-22-, 1929 and that death occurred, on the date stated above, at 8,10 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

..... (duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) W. T. Hargis, M. D.
11-23-1929 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: Nov 26 1929

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 orleans st

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51257

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51257

CERTIFICATE OF DEATH

74

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3447 Roland Ave. ST., 13-52 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Kopp

(a) RESIDENCE NO. 3447 Roland Ave. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Kopp

6 DATE OF BIRTH (month, day, and year) Nov. 17-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co. Pennsylvania

PARENTS

10 NAME OF FATHER Abtile Fruhsman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Lida Utz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Miss. Portia E. Kopp.

(Address) 3447 Roland Ave

15 Filed NOV 24 1929 Registrar C. HAMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1929, to Nov 21st, 1929, that I last saw h alive on Nov 21st, 1929, and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jordan Denwood M. D.

Nov 23 1929 (Address) 846w 36th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden — DATE OF BURIAL Nov. 25. 1929

20 UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Road

Spec.—2-20-28—L. F. S.—500 Bks.

Toston

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51258

CERTIFICATE OF DEATH

117 E 51258

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Toston

(a) RESIDENCE NO. 1312 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Riley Toston

6 DATE OF BIRTH (month, day, and year) June 8 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Companion to

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John J Peake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..., 19... C. HAMILTON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/29

17 I HEREBY CERTIFY, That I attended deceased from 11/18, 1929, to 11/22, 1929

that I last saw h er alive on 11/22, 1929

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix (perforated)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/21/29

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm H McPaul Jr. M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 11/25 19 29

UNDERTAKER

ADDRESS Angelo Fraley Sutton Fayette

7 AON

Spec.—2-29-28—L. F. S.—500 Blks.

Grant.

HEALTH DEPARTMENT—CITY OF BALTIMORE

259

CERTIFICATE OF DEATH

X 43

E 51259

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Donald Grant

(a) RESIDENCE NO. K. of C. Club 60th & Madison Ave - N. Y. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sardinia Hill Grant.

6 DATE OF BIRTH (month, day, and year) May 30, 1848

7 AGE	Years	Months	Days 24	If LESS than 1 day, hrs. or min.
	81	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer City of New York 061

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Donald Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Beebe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

11 Informant Deceased

(Address)

15 Filed 2-4-1929 C. HUGHSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929 to Nov. 24, 1929

that I last saw ~~him~~ alive on Nov. 24, 1929

and that death occurred, on the date stated above, at 5.05 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of jaws (right) with metastases.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy. (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Previous diagnosed elsewhere

(Signed) Samuel McLanahan, M. D.

Nov 24 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem. N.Y.	Nov. 26 1929
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Son	N. Y. City

Important.—See instructions on back of Certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51260

CERTIFICATE OF DEATH

90 E 51260

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5312 Anglewood Ave St. 27-44

2-FULL NAME August Saur Sr.,

(a) RESIDENCE NO. 5312 Anglewood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Barbara Saur

6 DATE OF BIRTH (month, day, and year) Sept 8/1857

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	72	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Palto., Md.

PARENTS

10 NAME OF FATHER Christian Saur

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Metzery

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant George Saur (son)
(Address) 5312 Anglewood Ave.

15 Filed NOV 24 1929 M. E. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Senility

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

11/22/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 25 29
20 UNDERTAKER	ADDRESS
William G. Schaefer Est. & Monument	

important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 57261

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 57261

CERTIFICATE OF DEATH

72

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 603 Lemmon, ST. 13-20 (WARD)

2—FULL NAME CHARLES WILLIAM KELLY

(a) RESIDENCE NO. 603 Lemmon ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13-1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48.	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman.

(b) General nature of industry, business, or establishment in which employed (or employer) Electrician C.T.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Simon Kelly.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annetta Cahill.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mary Kelly.
(Address) 603 Lemmon St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22nd 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 19 26 to Nov 22, 19 29
that I last saw him alive on Nov 20, 19 29.
and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis —

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ileo-Colitis 3

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. Emmy M.D. M. D.

, 19 (Address) 6 West N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Govans	11-25-1929
20 UNDERTAKER	ADDRESS
Martin Faber & Son	1921 W North Ave

Spec.—2-29-28—L. P. S.—500 Blks.

E 5/262 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 5/262

CERTIFICATE OF DEATH

E 5/262

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3216 Elmora Ave ST. S-40 WARD)

REGISTERED NO. E 5/262

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME THOMAS SWANN FEFEL

(a) RESIDENCE NO. 3216 Elmora Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Katharine Febel

6 DATE OF BIRTH (month, day, and year) Sept 13 - 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1 2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) Radio

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph S Fefel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amanda Moberly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Katharine Fefel

(Address) 3216 Elmora Ave.

15 Filed 2 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22nd 29.

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Nov. 22, 1929, that I last saw him alive on Nov. 21, 1929 and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) F. H. McGlelan M. D.

11/23/29 (Address) 2707 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	11-25-1929
20 UNDERTAKER	ADDRESS
Martin Feeley & Sons	1827 W North Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 51263

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51263

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. E 51263

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1006 St George Rd (ST.) Pimlico (WARD)

2—FULL NAME Richard L White

(a) RESIDENCE NO. 1006 St George Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Janet MacLaren

6 DATE OF BIRTH (month, day, and year) June 9 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Francis White

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Jane Janney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Miles L White Jr.

(Address) 4603 Kenway Road

15 Filed NOV 24 1929 JAMES H. JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Nov 22, 1929, that I last saw h~~im~~ alive on Nov 22, 1929, and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:

Coronary artery thrombosis

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis - Arteriosclerosis

Symptoms (duration) yrs. 3 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Nov 23, 1929 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Nov 25 1929
20 UNDERTAKER Henry H Gardenhour Sons	ADDRESS McCulloh & Eutaw

Cor.—10-16-29—A Co.—100 Bks.

E 51264

HEALTH DEPARTMENT—CITY OF BALTIMORE

E · 51264

CERTIFICATE OF DEATH

E 51264

113

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 16-68 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Velma F. Easton

(a) RESIDENCE NO. 2716 Prospect St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	0	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wilbur Easton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruby Landis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) W. Va

14 Informant Mrs. W. Easton
(Address) 2716 Prospect St

Filed ... 19 ... Registrar

NOV 24 1929 W. [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 2716 Prospect St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Gilbert, M. D.

11/24 19 29 (Address) 2739 Easterwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist. to Fee Mfg. Taylorsville Cemetery

DATE OF BURIAL Nov. 26 1929

20 UNDERTAKER C. M. Waltz

ADDRESS Mayfield Md.

OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51265

CERTIFICATE OF DEATH

E 51265

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin & Park Ave. St. 11-25 Ward)

2-FULL NAME Ingbel Hammond.

(a) RESIDENCE NO. New Market Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) 669
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jno Hammond

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Simpson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant W. E. Falconer
(Address) New Market.

15 Filed ....., 19..... C. HARRISON JONES, M. D.
V 25 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

(Inquest, autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Suicide by Jumping from window while Insane with Lumbago Mental aberration Cut wrists (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. skull (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Riley M.D. Coroner M. D.

Nov 24, 1929 (Address) 669 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetary Frederick

DATE OF BURIAL 12-16 1929

20 UNDERTAKER W. E. Falconer

ADDRESS New Market.

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51266

CERTIFICATE OF DEATH

24-001

E 51266

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital (If not in a hospital, STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Catherine Thomas Hilbert

(a) RESIDENCE NO. Mt. Royal apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick, Md.

PARENTS

10 NAME OF FATHER Lewis M. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Catherine Agle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Mr. Thomas Hilbert

(Address) Brooklandville, Md.

15 Filed NOV 25 1929 H. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1929, to Nov. 24, 1929,

that I last saw h e alive on Nov. 24, 1929

and that death occurred, on the date stated above, at 10 34 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Walter A Baetjer, M. D.

Nov. 25, 1929 (Address) 115 St Paul St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem Frederick Md	Nov 25 1929
20 UNDERTAKER	ADDRESS
Henry W Jenkins Sons	Cathedral & Centre Sts

Spec.—8-16-29—L. F. S.—100 Bks.

E 51267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 51267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 N. Milton ave ST. 6-10 WARD)

2—FULL NAME Patrick Henry O'Malley

(a) RESIDENCE NO. 112 N. Milton Av. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50+ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Henry

6 DATE OF BIRTH (month, day, and year) 11/26/1859

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
69	11	26	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegr. Opr. 73

(b) General nature of industry, business, or establishment in which employed (or employer) P. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James O'Malley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm. O'Malley

(Address) 112 N. Milton Av.

15 Filed DEC 5 1929 C. H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/29

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to Nov 21st, 1929, that I last saw h[illegible] alive on Nov 21st, 1929, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Heart

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Nursing Chart

(Signed) H. J. Franklin, M. D.

. 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 11/25/29

20 UNDERTAKER J. Walter Jenkins

ADDRESS 1633 E Monument

Cor.—10-10-29—A Co.—100 Bks.

51268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51268

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 9-17 Ward)

2-FULL NAME Sister Mary Joseph Labadee

(a) **RESIDENCE NO.** Convent at Leavenworth St., Kansas Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30-1872

7 AGE	Years	Months	Days 27	IF LESS than 1 day ..hrs. or ..min.
	57	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious
(b) General nature of industry, business, or establishment in which employed (or employer) 065
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) St. Louis, Mo.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs. Robt. Elliott
(Address) 1725 Ashland Ave

15 Filed NOV 25 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (Chronic)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/23/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral	Nov. 23 1929
20 UNDERTAKER Wm. A. G. Elliott	ADDRESS 1725 Ashland Ave

IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51269 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51269

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Newington Ave St. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Engelhaupt.

(a) RESIDENCE NO. 865 Newington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 14-1840

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Adam Engelhaupt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Stichert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma E. Engelhaupt (Address) 805 Newington Ave

15 Filed 12 5 1929 C. HAMILTON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov 23, 1929.

that I last saw h alive on Nov 22, 1929.

and that death occurred, on the date stated above, at 2.a m.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Endocarditis

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? V

(Signed) Jeffers Buck, M. D.

11 23, 1929 (Address) 710 S. Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 11/25 1929

20 UNDERTAKER Chas F. Wawe & Son

ADDRESS 1810 W. Royal Ave

TION is very imprtant. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51270

CERTIFICATE OF DEATH

47 E 51270

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2215 Mondawmin Road WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Silverman

(a) RESIDENCE NO. 2215 Mondawmin ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 34 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Samuel Abrams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Celia Sesol

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Abrams

(Address): 2215 Mondawmin ave

15 Filed: 2 5 1929, 19

C. HAMPSON JONES, M. D.

Per Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 19 29, to Nov. 24, 19 29

that I last saw her alive on Nov. 23, 19 29

and that death occurred, on the date stated above, at 10:25 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of the Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion (duration) 1 year mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? As above stated and Exhaustion and Hypostatic Pneumonia

(Signed) Lewis K. Shaine, M. D.

Nov 24 19 29 (Address) 2302 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holomes Rosedale

DATE OF BURIAL: 11/25 19 29

20 UNDERTAKER: A. L. Winson

ADDRESS 1127 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51271

74-001 E 51271

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 E 33rd ST., 9-46 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Angel

(a) RESIDENCE NO. 702 E. 33 st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Angel.

6 DATE OF BIRTH (month, day, and year): April 26 1865.

7 AGE — Years: 64 — Months: 6 — Days: 28. — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt.

PARENTS

10 NAME OF FATHER: John Rosenberger.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary E. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Jos. H. Angel. (Address) 702 E. 33 st

15 Filed NOV 25 1929 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1929, to Nov 24, 1929, that I last saw h[er] alive on Nov 23, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy —

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

11/25 (Signed) Jos. H. Kinzey, M. D.

1929 (Address) 2700 Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 11 27 1929

19 UNDERTAKER: George L. Ruth

ADDRESS: 1725 Oxford Av

Spec.—2-29-28—L. F. S.—500 Bks.

E 51272 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-002 11-E 51272

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Ross

(a) RESIDENCE No. 1431 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Nick Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Mary Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Record
(Address)

15 Filed 2 5 1929, 19 C. HAMPSON JONES, M. D. Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-29

17 I HEREBY CERTIFY, That I attended deceased from 9-30, 1929, to 11-24, 1929, that I last saw h[illegible] alive on 11-24, 1929 and that death occurred, on the date stated above, at 8-30 a. m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer
Abdominal Adhesions
Chronic Obstruction
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 10-16-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

11-24, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 11 26 1929

20 UNDERTAKER George & Ruth — ADDRESS 1700 Harford Avenue

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51273

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 51273

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 667 W. Biddle ST. 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Lopez

(a) RESIDENCE NO. 567 W Biddle ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~6 yrs. 6 mos.~~ dk How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Nancy Lopez
(Address) 567 W Biddle

15 Filed [illegible] 25 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to Nov 24, 1929, that I last saw him alive on Nov 21, 1929 and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

11/24. 1929 (Address) 705 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 11-25 1929

20 UNDERTAKER David Easton — ADDRESS 916 Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51274

37-002

E 51274

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-27 WARD)

2—FULL NAME Walter Bonner

(a) RESIDENCE NO. 834 N. Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-21-97

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	32	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silk Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Edward Bonner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Bonner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 12-5-1929 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-23-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov 23, 1929, that I last saw him alive on Nov 23, 1929, and that death occurred, on the date stated above, at 155 A m.

The CAUSE OF DEATH* was as follows:

Polyneuritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculosis,

(Signed) C. V. Bingel, M. D.

19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Belen Burg Va.	11-25-1929
20 UNDERTAKER Bauer Eastern	ADDRESS 916 Pa ave.

Spec.—2-29-28—L. F. S.—500 Bks.

3E 51275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 E 51275

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 425 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Parker Taylor

(a) RESIDENCE NO. 5-14 Vine St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/2/27

7 AGE — Years: 2 | Months: 2 | Days: 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER James Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Estelle Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 5 1929 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23-29

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1929, to Nov. 23, 1929, that I last saw her alive on Nov. 23, 1929, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of meninges

(duration) yr. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

11/23, 1929 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 11-25 1929

20 UNDERTAKER: Frank Taylor

ADDRESS 516 Park Ave

Spec.—8-16-29—L. P. S.—100 Blks.

E 51276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 51276

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3100 Walcott Ave., ST. 15-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harold N. Flirshman

(a) RESIDENCE NO. 3100 Walcott Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Isreal Flirshman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Weltzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E Bala. St

15 Filed NOV 25 1929, 19

HARRISON JONES

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929, to Nov. 24, 1929, that I last saw h[illegible] alive on Nov. 24, 1929, and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) John Rubish, M. D.

19 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbutus Cemetery	Nov. 25-1929

20 UNDERTAKER Jack Lewis, 1439 ADDRESS E Bala St.

Cor.—10-10-29—A Co.—100 Blks.

E 51277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 51277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1618 John St. 14-20 Ward)

2-FULL NAME Mary E. McNiel

(a) RESIDENCE NO. 1618 John St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 8 1929

7 AGE: Years | Months 3 | Days 15 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Wm A McNiel

11 BIRTHPLACE OF FATHER (city or town): Maine
(State or country)

12 MAIDEN NAME OF MOTHER: Josephine Bosley

13 BIRTHPLACE OF MOTHER (city or town): Baltimore md
(State or country)

14 Informant: Josephine Bosley
(Address) 1618 John St

15 Filed ....., 19.... H. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Hirsh, M. D.

(Address) Boarder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect (Towson)

DATE OF BURIAL: Nov 25 1929

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 424 W Lexington St.

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51278

CERTIFICATE OF DEATH

E 51278

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 Evergreen Ave. (STREET) 27-43 (WARD))

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salem Wesley Pocock.

(a) RESIDENCE NO. Sweetair Hall Co. 2nd WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bachlor.

6 DATE OF BIRTH (month, day, and year) Sept 5, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co

PARENTS

10 NAME OF FATHER John Pocock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Mary Hendrickson

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Pennsylvania

14 Informant Mrs E. Pocock
(Address) Phoenix Md.

15 Filed 25 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Nov 24, 1929 that I last saw him alive on Nov 24, 1929 and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Cancer of Cervical gland.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Result of injury

Did an operation precede death? No Date of Nov 8 1928

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno D Fleming M. D.

Nov 25, 1929 (Address) 1834 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland Cem. DATE OF BURIAL Nov 28 1929

20 UNDERTAKER John Burns Sons ADDRESS Towson

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51279

1-PLACE OF DEATH

CERTIFICATE OF DEATH

161-09

E 51279

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Hopkins Hospital St. 21-24 Ward)

2-FULL NAME Gilbert Thompson

(a) RESIDENCE NO. 1241 Washington Boul St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24/29

7 AGE	Years	Months	Days	IF LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Thomas Thompson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Newman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Thomas Thompson
(Address) 1241 Washington Boulv

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Baer, M. D.

1/20/29 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem'

DATE OF BURIAL 11/25 1929.

20 UNDERTAKER Harry H Wright

ADDRESS 1530 W. Lombard

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51280

CERTIFICATE OF DEATH

90 ✓

E 51280 REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ____ ST. H-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Peddicord.

(a) RESIDENCE NO. 46 Market Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General labourer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Henry Peddicord

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Nicholson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Records (Address) Baltimore City Hospitals.

15 Filed ..... 19 .....

NOV 25 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929. to Nov 23, 1929. that I last saw h alive on Nov 23, 1929 and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) more than 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Lab.

(Signed) Marvin W. McClean, M. D.

Nov 24 1929 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co. Finchum's Chapel — DATE OF BURIAL Nov. 26 1929

20 UNDERTAKER Harry A. Witzke, 1531 W. Lombard St — ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5128 I

CERTIFICATE OF DEATH.

45 E 5128 I

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1333 2. Fulton ave (Ward) 5-26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma B. Allen.

(a) RESIDENCE NO. 1333 2. Fulton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George M. Allen

6 DATE OF BIRTH (month, day, and year) Dec, 2, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John G. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Burgett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George M. Allen

(Address) 1333 2. Fulton ave

15 Filed 25 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Nov 22, 1929, that I last saw her alive on Nov 22, 1929, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the rectum

metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 1

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Examination

(Signed) Walter A. Coe, M. D.

(Address) 541 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. — DATE OF BURIAL Nov 26 1929

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 51282 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51282

CERTIFICATE OF DEATH. 101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1027 N. Parrish 16 27 (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Smith.

(a) RESIDENCE NO. 1027 N. Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): — 1889

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Rosa Hebron

(Address) 821 Parrish St

Filed NOV 25 1929 C. HAMILTON JONES, M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/21/1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1929. to Nov. 21, 1929.

that I last saw her alive on Nov. 21, 1929.

and that death occurred, on the date stated above, at 7.15 p. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. M. Figgs M. D.

11/24 1929 (Address) 1536 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Nov. 25 1929

20 UNDERTAKER: Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Cor.—10-10-29—A Co.—100 Bks.

E 51283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 E 51283

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 912 Granby St. 3-5 Ward)

2-FULL NAME CECELIA WEISE

(a) RESIDENCE NO. 912 Granby St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth 81 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert Weise

6 DATE OF BIRTH (month, day, and year) April 14, 1838

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	91	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mr. Charles Weise (Son)
(Address) 912 Granby St.

Filed NOV 25 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

CONTRIBUTORY (Secondary) C & L Cancer (duration) 1 yrs. mos. da.

(duration) yrs. mos. 1 da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) H. C. Eadie, M. D.

19 (Address) 1436 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov. 26 19 9

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: Baltimore & Broadway

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51284

CERTIFICATE OF DEATH

90 E 51284

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 26-37 S., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Kahl

(a) RESIDENCE NO. 120 S. Haven ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth?— yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Kahl.

6 DATE OF BIRTH (month, day, and year) Oct 11. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58 ?	2 1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 030

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. H. A. Kahl

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Seifert

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Germany

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed NOV 29 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-29

17

I HEREBY CERTIFY, That I attended deceased from 11-15, 1929, to 11-22, 1929, that I last saw h.. alive on 11-22, 1929 and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Interst.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. & P.E.

(Signed) Warren H. McLean, M. D.

11-23, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 26 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	Baltimore St. & Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 51285

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-00 E 51285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 806 Asquith ST. 10-1H (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chauncey Champlin Jr.

(a) RESIDENCE NO. 806 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24, 1927

7 AGE 2 Years Months 9 21 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chauncey Champlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Rosie Smyth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Rosie Champlin (Mother)

(Address) 816 Asquith st

15 Filed 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929, to Nov 24, 1929, that I last saw him alive on Nov 23, 1929, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. Lyerly, M. D.

11/24/29 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 11-25 1929

20 UNDERTAKER Byron & Wright

ADDRESS 1218 Mc & Elderry St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Lochowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

51286

CERTIFICATE OF DEATH

167-001 E 51286

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1621 Front St. 24 Ward)

2-FULL NAME Josef Lochowski

(a) RESIDENCE NO. 1621 Front St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1883.

7 AGE: 46 years | Months: 10 | Days: | IF LESS than 1 day hrs. or min.

45

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Andy Lochowsky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Anna Stanczak

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Martha Wierzbowska
(Address) 402 N. Milton Ave

15 Filed 1929 C. HAMPSON JONES, M. D.
By Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH was as follows:

Suicide
Gas Poisoning Ill.
(duration) yrs. mos. 6 hr. ds.
CONTRIBUTORY (Secondary) Asphyxia
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? By Coroner
No. 5579 Geo Clinton Blades M. D.
(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus

DATE OF BURIAL: Oct 26 1929

20 UNDERTAKER: F W Rozanski

ADDRESS: 1930 Eastern Ave

IMPORTANT. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51287

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 818 W. Pratt St.) 18-29 (Ward)

2-FULL NAME Rachel Carr

(a) RESIDENCE NO. 914 Boyd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced: (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 070

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Jim Carr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Rena Dixon
(Address) 914 Boyd St

15 Filed ..... C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeltz, M. D.

11/25, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery — DATE OF BURIAL 11/26 1929

20 UNDERTAKER Walter B. Spragg — ADDRESS 1924 Eastern Ave

Important. See instructions on back of certificate.

C HAMILTON JONES M D

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51288

CERTIFICATE OF DEATH.

129 E 51288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Plumb Alley ST. 2335 Ward 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Caldwell

(a) RESIDENCE NO. 911 Plumb Alley ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Charlie Caldwell

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 49 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): House wife

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Mt. Airy, Md

PARENTS

10 NAME OF FATHER: James Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Union Town Md

12 MAIDEN NAME OF MOTHER: Cassie Jobes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Union Bridge Md.

14 Informant: Mary Caldwell

(Address) 911 Plum alley

15 Filed NOV 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/23/1929

17

I HEREBY CERTIFY, That I attended deceased from 11/22/, 1929, to 11/23/, 1929, that I last saw her alive on 11/22/, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

Pulmonary hypostasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis (duration) ..... yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical history

(Signed) W. H. Baker, M. D.

, 19 (Address) 709 Hart St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calary Cemtry

DATE OF BURIAL: 11/25 1929

20 UNDERTAKER: Walter B. Sprigg

ADDRESS 1539 No. Hamby st.

Cor.—10-10-29—A Co.—100 Bks.

E 51289

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51289

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hospital-No Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah West

(a) RESIDENCE NO. 316 Myrtle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Colored | 5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa

6 DATE OF BIRTH (month, day, and year): Dec 15-1900

7 AGE: Years 29 | Months 11 | Days 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Va
(State or country):

PARENTS

10 NAME OF FATHER: Thos West

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country):

14 Informant: Louise West
(Address): 316 Myrtle St

15 Filed ..... 19..... HAMPSON JONES
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....da.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Regular

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov 23 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 11/25/1929

20 UNDERTAKER: Wm. Geo. A. Holland — ADDRESS 1631 Druid Hill Ave

important. See instructions on back of certificate.

DEC 5 1929

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 51290
1 PLACE OF DEATH

CERTIFICATE OF DEATH

31
E 51290
REGISTERED NO. C

CITY OF BALTIMORE (No. 2437 Druid Hill Ave ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Douglas Montgomery

(Residence in Baltimore: No. 2437 Druid Hill Ave St.: 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June - 22 - (Month) (Day), 1904 (Year)

7-AGE: 25 yrs. 4 mos. 29 ds. (5 2) If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Virginia

PARENTS

10-NAME OF FATHER: James Douglas

11-BIRTHPLACE OF FATHER (State or country): Virginia

12-MAIDEN NAME OF MOTHER: Smith

13-BIRTHPLACE OF MOTHER (State or country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Douglas

(Address) 2437 Druid Hill

15. NOV 25 1929, 19... E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November - 24 -, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July - 2 -, 1929 to Nov - 24 - 1929, that I saw her alive on Nov - 24 - 1929, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Pyo-Nephrosis

(Duration) One yrs. 4 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Herman Seidel M. D.

Nov 24, 1929 (Address) Herman Seidel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Glouster Point, Va. DATE OF BURIAL: 11/25/1929

20-UNDERTAKER: Chas. H. Alexander ADDRESS: 1406 Druid Hill

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of FACT is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 5129 I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 5129 I

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 7-13 Ward)

2-FULL NAME Ida B. Fisher

(a) RESIDENCE NO. 915 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21/1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Robt. B. Fisher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna Walker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs. M. V. Fisher
(Address) 202 Warren Ave

15 Filed 19 H. HANSON KEYS, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/23/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — DATE OF BURIAL: Nov 25 1929

20 UNDERTAKER: Wm. C. Black — ADDRESS: 927 N. Broadway

IMPORTANT. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr. Chas Keller 222 W. Monument 44V

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51292

CERTIFICATE OF DEATH

E 51292

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 303 E. North Ave (St.) 11-15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John B Wilde

(a) RESIDENCE NO. 303 E North ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Wild

6 DATE OF BIRTH (month, day, and year) Oct 5 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 08

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER August Wm A Wild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Virginia Wilson

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mary J. Wilde

(Address) 303 E North Ave

15 Registrar HAMILTON JONES, M. D.

NOV 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10 1929, to Nov 23 1929, that I last saw h alive on Nov 21 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Tongue

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) none known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 29

Was there an autopsy? no

What test confirmed diagnosis? X ray + blopsy

(Signed) Chas J Keller, M. D.

11/23, 1929 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Nov. 25 1929

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

Spec.—1-10-21—M&T—1500 Bks.

51293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 49E 51293

1-PLACE OF DEATH Howard Kelly Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No.) 1418 Eutaw Place (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Agustus Ellard

(a) RESIDENCE NO. Howard Kelly Hospital ST., WARD Bristol, West Virginia

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Ellard

6 DATE OF BIRTH (month, day, and year) Oct 24th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	54	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain of Police

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Railways

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Birmingham Alabama

PARENTS

10 NAME OF FATHER Willis Ellard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Birmingham Alabama

12 MAIDEN NAME OF MOTHER Jane Tuckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Birmingham Alabama

14 Informant Guy Ellard

(Address) Bessemer Alabama

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

NOV 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1929, to Nov 24th 1929, that I last saw him alive on Nov 24th, 1929 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? West Virginia

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edmund Kelly, M. D.

Nov 24 1929 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Birmingham Ala — DATE OF BURIAL 11/25 1929

20 UNDERTAKER Wm Cook — ADDRESS St Paul St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51294

CERTIFICATE OF DEATH

179 E 51294

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 21-29 Ward)

2-FULL NAME Alvatine Brown

(a) RESIDENCE NO. 848 Rinehart St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Drury Brown

6 DATE OF BIRTH (month, day, and year) Sept 3, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Grist

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Annie McKnew

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Mrs. Herbert Brown
(Address) 848 Rinehart St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

W 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second degree burns of Entire body & thighs - right leg. Accidental death

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 848 Rinehart St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

11/27 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 11/26 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 Druid

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51295

CERTIFICATE OF DEATH

16 001 E 51295

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1011 Ensor St., 9-18 Ward)

2-FULL NAME Harry Hallock, Sr.

(a) RESIDENCE NO. 1011 Ensor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Hallock

6 DATE OF BIRTH (month, day, and year) July 31/1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paperhanger
(b) General nature of industry, business, or establishment in which employed (or employer) 057
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Edward Hallock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Pennington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mary C. Hallock
(Address) 2023 N. Charles St

15 Filed NOV 25 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas asphixiation
(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

11/23/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 11/26 1929

20 UNDERTAKER [signature] — ADDRESS 1217 E. Fayette St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Blks.

E 51296 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-001

CERTIFICATE OF DEATH E 51296

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Division ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James L. Hooper

(a) RESIDENCE NO. 1414 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hooper

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER James Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Julia Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Silas Hull

(Address) 1705 W. Washington St.

15 Filed 23 1929 C. Plan[illegible] Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Nov 23, 1929, that I last saw h[illegible] alive on Nov 23, 1929 and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) B. K. Fletcher M. D.

11/23, 1929 (Address) 1715 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore MD

DATE OF BURIAL 11-26 1929

20 UNDERTAKER George P. A. Gibson

ADDRESS 1735 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

REGISTERED NO. E 51297.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie Hutchison

(a) RESIDENCE NO. 579 Greenwillow ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. ? How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ....., 19 .....
(Registrar)

W 25 1929 HAMPSON JONES, M. D.
THE MORGUE 4092

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 19 29 to Nov. 19, 19 29

that I last saw her alive on Nov. 19, 19 29

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

" of CNS

(duration) ..... yrs. / mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonalis

(duration) ..... yrs. / mos. ..... ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wass. & C. Spinal

(Signed) Marion Kelly McClean, M. D.

11-21, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	
20 UNDERTAKER Com. Edgelcomer Health	ADDRESS NOV 25 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51298

E 51298

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 10-14

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Yates

(a) RESIDENCE NO. 733 (Usual place of abode) 733 Greenmount Ave. ST., ... WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER H.P.P. Yates

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Matten

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed NOV 25 1929, 19 HAMPSON JONES, M.D. Registrar

THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 29, 19..... to Nov. 19, 29, 19.....

that I last saw him alive on Nov. 19, 19 29

and that death occurred, on the date stated above, at 1:25 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute

..... (duration) ..... yrs. over 14 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C. Exam.

(Signed) Warren H. McLean, M. D.

11-21, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL VERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS NOV 25 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51299 E 51299

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 10-37 Ward) 31

2-FULL NAME James Hawkins

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ....., 19.... HAMPSON JONES, M. D.
Registrar

4090

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cut T B.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

NOV 25 1929

Per M. B. WOOLA...

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

51300

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51300

CERTIFICATE OF DEATH

76

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 N. Hushurst St. WARD) 8-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Schweigtenburg.

(a) RESIDENCE NO. (Usual place of abode) 1623 N Hushurst ST. WARD

Length of residence in city or town where death occurred 54 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of divorced

6 DATE OF BIRTH (month, day, and year) Jan. 7 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	66	10.	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silversmith

(b) General nature of industry, business, or establishment in which employed (or employer) Stieff Silver Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Schweigtenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mother (Address) 1623 N Hushurst

15 Filed NOV 25 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/21/29.

17 I HEREBY CERTIFY, That I attended deceased from 11/14/ 1929 to 11/21/ 1929, that I last saw h alive on 11/20/ 1929 and that death occurred, on the date stated above, at 4.35 A.M.

The CAUSE OF DEATH* was as follows:

Paresis -

Chronic Myocarditis (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) George Abner Dawson, M. D.

11/22 1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Nov 25 1929.
20 UNDERTAKER	ADDRESS
Wendell & Peppel	3rd & Eden

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5130r

CERTIFICATE OF DEATH

129 E 5130r

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 20-69 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Johnson

(a) RESIDENCE NO. 2804 Frederick Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rhoda J. Johnson

6 DATE OF BIRTH (month, day, and year): May 16 1885

7 AGE: 44 Years | Months 6 | Days 8 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): ? Odd

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Va.

12 MAIDEN NAME OF MOTHER: Sarah Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Va.

14 Informant: Records
(Address)

15 Filed 2 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-27-29

17 I HEREBY CERTIFY, That I attended deceased from 11-6, 1929, to 11-27, 1929, that I last saw him alive on 11-24, 1929 and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Arteriitis Pyaemia

over 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, 5 days

Pleuritis, chronic (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & Hosp.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. & C. Tissue X-ray

(Signed) Marvin M. McKean, M. D.

11-27, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk Cem

DATE OF BURIAL: 11/26 1929

20 UNDERTAKER: J. Few Mc Cully

ADDRESS: 130 E. Fort

Spec.—2-29-28—L. F. S.—500 Blks.

51302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89

E 51302

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3735 E. Lombard ST. 26-37 WARD)

2—FULL NAME Wm H. Keys

(a) RESIDENCE NO. 3735 E. Lombard ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Keys

6 DATE OF BIRTH (month, day, and year) Mar 30/1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar & Tob

(b) General nature of industry, business, or establishment in which employed (or employer) Confectionary

(c) Name of employer (Himself) Store

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary - -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna E. Keys

(Address) 3735 E. Lombard

15 Filed Nov 25, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1929 to Nov. 23, 1929 that I last saw him alive on Nov. 22 1929 and that death occurred, on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Frank A. Glantz, M. D.

Nov. 25, 1929 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Mem

DATE OF BURIAL Nov 26 1929

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

Spec.—1-12-23—M&T—500 Bks.

1303

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51303

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary ST. 11-24 (WARD)

2-FULL NAME Robert B Womble

(a) RESIDENCE NO. Work opt N Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1st 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Pembroke M Womble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Chappell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant ..... (Address) Pembroke M Womble

15 1929 ....., 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1929

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1928, to Nov 24, 1929,

that I last saw h.. alive on Nov. 23, 1929,

and that death occurred, on the date stated above, at 2200 m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with
Cerebral Hemorrhage

(duration) 1 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observed from

(Signed) Vernon H. Norris, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. Com

DATE OF BURIAL 11-29 1929

20 UNDERTAKER Percy W. Jenkins Funeral Home

ADDRESS Richmond

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51304 ✓ E 51304

CERTIFICATE OF DEATH

21

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 702 Homestead St. (Hosp.)

2—FULL NAME Albinus Schuck

(a) RESIDENCE NO. 702 Homestead St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. How long in U. S., if foreign birth? 57 yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Schuck

6 DATE OF BIRTH (month, day, and year) May 9th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Schuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schiffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Schuck

(Address) 702 Homestead St.

15 Filed 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1929 to Nov. 23, 1929, that I last saw him alive on Nov. 21, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Senility

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Wm. B. Dyberg, M. D.

, 19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Nov. 26, 29

20 UNDERTAKER: Wm. H. Valentine ADDRESS: 7326 Aiken St.

Spec.—8-16-29—L. F. S.—100 Bks.

Beery Burry

E 51305

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 51305

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1326 Homestead (St.) Apt 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick J Burry.

(a) RESIDENCE NO. 1326 Homestead ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 19 29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. md.

PARENTS

10 NAME OF FATHER Frederick J Burry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Mary A Heyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Frederick J Burry

(Address) 1326 Homestead st

15 Filed 25 1929, 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 24, 1929,

that I last saw him alive on Nov. 24, 1929

and that death occurred, on the date stated above, at 8 00 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Otitis Media & Tonsilitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? nad

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 3200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Geo. L. Rutt

DATE OF BURIAL Nov 26 1929

20 UNDERTAKER Richmond County

ADDRESS 1735 Hanford ave ~~1735 Hanford ave~~

Spec.—1-10-21—M&T—1500 Bks.

E 51306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 E 51306

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 12-31 WARD)

2-FULL NAME Paul E. Nelson

(a) RESIDENCE NO. 11 North Square, Boston, Mass ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ..... ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A.B.Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Vacuum"

9 BIRTHPLACE (city or town) .....
(State or country) Ohio

PARENTS

10 NAME OF FATHER Orville Nelson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Florence Travis

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ohio

14 Informant Records, U.S. Marine Hospital
(Address)

15 Filed 2 5 1929 C. HAMPSON JONES, M. D. Registrar

PGT NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 19 29

17 I HEREBY CERTIFY, That I attended deceased from August 26, 19 29, to November 21, 19 29, that I last saw him alive on November 21, 19 29, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, acute, miliary

..... (duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Ralph E. Porter, M. D.

11/21/29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION, REMOVAL St. Mary's Cemetery, DATE OF BURIAL Nov 25, 1929

20 UNDERTAKER E. LeRoy Stafflet, Inc ADDRESS 125 E North Ave

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 E 51307

1—PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital St. 6-26 WARD)

2—FULL NAME Thomas Lutz

(a) RESIDENCE NO. 1936 W. Lanvale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Dallas Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Frances Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Dallas Lutz
(Address) 1936 W. LaDvale St.

15 Filed NOV 25 1929 19 C. HAMPSON JONES, Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929 to Nov 25, 1929, that I last saw him alive on Nov 24, 1929 and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever (Septic Type)

(duration) 0 yrs. 0 mos. 13 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 1936 W. Lanvale St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Jr. M. D.

11-25 1929 Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemt

DATE OF BURIAL Nov 26 1929

20 UNDERTAKER Pretlow & Son

ADDRESS 1723 W. Lafayette Ave

Spec.—1-10-21—M&T—1500 Blks.

E 51308

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51308

CERTIFICATE OF DEATH.

REGISTERED NO. 149

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Park Ave. ST. 11-25 WARD)

2-FULL NAME Simon Oberaitis

(a) RESIDENCE NO. 514 N. Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of India Stone

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	0	27 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. India Oberaitis (Address) 514 Park Ave.

15 Filed 25 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9. 1929, to Nov. 24. 1929, that I last saw him alive on Nov. 23. 1929, and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical findings & X ray

(Signed) A. V. Buchness M. D.

11/25. 1929 (Address) 37 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. John's Cem. Hollywood Md. DATE OF BURIAL: 11/26/29

20 UNDERTAKER: Wm. Mears & Son ADDRESS: 805 N. Calvert St

Via automobile. — H. W. Mears — Escort

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E.51309 [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E. 51309 [redacted]

CERTIFICATE OF DEATH

84

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5411 Falls Road ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hanson Moore

(a) RESIDENCE NO. 5411 Falls Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 55 yrs. 5 mos. 24 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Alice May Moore

6 DATE OF BIRTH (month, day, and year): May-31-1874

7 AGE: Years 55 | Months 5 | Days 24 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wholesale Paper

(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

(c) Name of employer (Self)

9 BIRTHPLACE (city or town) (State or country): Harford Co. Maryland.

PARENTS

10 NAME OF FATHER: Wm. H. Moore

11 BIRTHPLACE OF FATHER (city or town) Southern (State or country) Maryland

12 MAIDEN NAME OF MOTHER: Alice S. Bird

13 BIRTHPLACE OF MOTHER (city or town) Southern (State or country) Maryland

14 Informant: Miss Alice M. Moore (Daughter)
(Address) 5411 Falls Road, Balto. City.

15 Filed ....., 19.... C. HERBERT JONES Registrar

2 5 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24. 1929

17 I HEREBY CERTIFY That I attended deceased from June, 1928, to Nov 24, 1929, that I last saw h alive on Nov 24 29, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

(a) Arteriosclerosis.

Cerebral Sclerosis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

5-6 yrs (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hiram Lyman Whittle, M. D.

19 (Address) 1224 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Nov 26 1929

20 UNDERTAKER: Edward W. Conn & Son — ADDRESS: Balto.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 51310

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Lucina Fanning.

(a) RESIDENCE NO. Mt St. Joseph Rutland Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 11, 1862

7 AGE — Years: 67 | Months: 6 | Days: 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): Convent

(c) Name of employer: Convent.

9 BIRTHPLACE (city or town) (State or country): St Johns. New Foundland

PARENTS

10 NAME OF FATHER: Edward Fanning

11 BIRTHPLACE OF FATHER (city or town) (State or country): New foundland

12 MAIDEN NAME OF MOTHER: Bridget Mona

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New foundland

14 Informant: Mt Hope Retreat

(Address): Mt Hope Retreat

Filed 25 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1928, to Nov 25, 1929, that I last saw her alive on Nov 23, 1929 and that death occurred, on the date stated above, at 3.30 a. m. 2.30

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Depressed Psychosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical.

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rutland Vermont — DATE OF BURIAL: Dec. 2 19 29

20 UNDERTAKER: Stewart Memorial Hall

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 51311

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51311

CERTIFICATE OF DEATH

X 45

1—PLACE OF DEATH

REGISTERED NO. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 13 Midvale Rd ST. (WARD)

2—FULL NAME Caroline Bradford

(a) RESIDENCE NO. 13 Midvale Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 24 ds. How long in U. S., if foreign birth? 73 yrs. 1 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H Bradford

6 DATE OF BIRTH (month, day, and year): Oct 11 1856

7 AGE: Years 73 | Months 1 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

PARENTS

10 NAME OF FATHER: Wilhelm Heuser

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER: Elise DeBus

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Germany

14 Informant: Mrs Elsa B. Dodd daughter

(Address) 13 Midvale Road

15 Filed Nov 25 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 8, 19 29, to Nov. 24, 19 29

that I last saw her alive on Nov. 24 19 29

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Growth of Inguinal

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Howard M Dubert, M. D.

11/25, 1929 (Address) 821 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn-N.Y. DATE OF BURIAL: Nov 26 19 29

20 UNDERTAKER: Stewart & Morris Co ADDRESS: Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51312

CERTIFICATE OF DEATH

45 E 51312

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Charles R. Wolf

(a) RESIDENCE NO. 922 University Parkway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Lillian Wolf

6 DATE OF BIRTH (month, day, and year): Nov. 17 1858

7 AGE: Years 71 | Months | Days 6 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John B. Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lillian Wolf

(Address) 922 University Parkway

15 Filed NOV 25 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/6, 1929, to Nov 23, 1929, that I last saw him alive on November 23, 1929, and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:

Pigmented mole of anal margin - malignant

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary and cerebral metastases (duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/10/29 & 10/7/29

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam.

(Signed) Leo. E. Stoeg, Jr. M. D.

19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	11/26/1929
20 UNDERTAKER: E. J. Moran	ADDRESS 306 E Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

E 51313

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51313

CERTIFICATE OF DEATH

1—PLACE OF DEATH Woman's Hospital REGISTERED NO. 161-021

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Roth

(a) RESIDENCE NO. 1733 Edmonson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Premature Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11-25-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Julius Frederick Roth

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Pauline St Clair

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Father (John Roth)

(Address) 1733 Edmonson Ave.

Filed 11-25-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1929, to Nov. 25, 1929, that I last saw him alive on Nov. 20, 1929, and that death occurred, on the date stated above, at 10:06 A.m.

The CAUSE OF DEATH* was as follows:

Spontaneous Premature Labor (24 weeks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Hydramnios

Fatality (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) Eleanor L. Mordyce M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woman's Hospital — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS NOV 25 1929

Commissioner of Health

Spec.—2-29-28—L. F. S.—500 Bks.

E 51314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-001 ✓ E 51314

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cooper

(a) RESIDENCE NO. 807 China ST., 22-31 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eliza Cooper

6 DATE OF BIRTH (month, day, and year) 12th Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S. C. (Charlestown)
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant City (Unable to give name and address) Inspector Bureau (undertaker)

15 Filed 2 5 1929, 19 C. HAMPSON JONES, M. D. Registrar

4095

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 - 29

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 19 29, to Nov 24, 19 29,

that I last saw h.m alive on Nov 24, 19 29

and that death occurred, on the date stated above, at 6 40 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) yrs. mos. 2 Cds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) A. Cooley M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

NOV 25 192

Spec.—1-12-23—M&T—500 Blks.

E 51315 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51315

CERTIFICATE OF DEATH. 132

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. Balto. Gen. Hosp. ST. 7-10 WARD)

2-FULL NAME Mrs. Gertrude Korb

(a) RESIDENCE No. 506 N. Eugene Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas L. Korb

6 DATE OF BIRTH (month, day, and year) Mar 28, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	45	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas L. Korb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Katherine McNeill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Miss Helen Korb

(Address) 506 N Eugene Ave

15 Filed NOV 25 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25/ 1929

17

I HEREBY CERTIFY, That I attended deceased from 11/7/, 1929, to 11/25/, 1929.

that I last saw h[illegible] alive on 11/7/, 1929

and that death occurred, on the date stated above, at 7.05 a m

The CAUSE OF DEATH* was as follows:

Bilateral renal calculi

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia & uremia (duration) yrs mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) J. V. Castagna, M. D.

(Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Nov 27, 1929

20 UNDERTAKER John Ulrich ADDRESS 2008 Ellerslie

Spec.—1-10-21—M&T—1500 Bks.

E 51316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51316

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST., WARD)

2-FULL NAME Mrs. Martha Cooper.

(a) RESIDENCE NO. 137 S. Linwood Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. Frances Cooper

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	64	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Mattison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rebecca McClintic

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Hospital Records

(Address)

15

2 5 1929 C. HAMPSON JONES, Registrar

BY .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/29 19

17

I HEREBY CERTIFY, That I attended deceased from 11/15/29, 19..., to 11/22/29, 19...,

that I last saw h.. alive on 11/22/29, 19...,

and that death occurred, on the date stated above, at 8 45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with empyema of left Bladder 1.

Chronic diffuse Hepatitis.

(duration) 1- yrs. mos da.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 8 da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes. Date of 11/17/29

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) J. H. Hampton, M. D.

(Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Nov 26 1929

20 UNDERTAKER John Merrick

ADDRESS 2008 Olleans

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51317 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51317

CERTIFICATE OF DEATH. 74-8

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (St.) 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Younger

(a) RESIDENCE NO. 1221 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Mrs Bertha Bryant (Address) 1322 H St NE Washington D.C.

15 Filed 2 5 1929, 19 C. EMERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 23, 1929, that I last saw him alive on Nov 23, 1929, and that death occurred, on the date stated above, at 10.41 P m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage into left parietal & occipital lobes.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? on street

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) M M Hurley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL Nov 26 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eden

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51318 128 E 51318

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 813 N. Howard ST. 11-24 WARD)

2—FULL NAME Conrad August Simmon

(a) RESIDENCE NO. 813 N. Howard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if foreign birth 36 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

(a If married, widowed, or divorced) HUSBAND of (or) WIFE of Annie Whittle Simmon

6 DATE OF BIRTH (month, day, and year) Dec 14 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	61	10 11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Rockefeller School of Hygiene

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Simmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Annie Whittle Simmon

(Address) 813 N. Howard st

15 Filed ..... 19 .....

25 1929 acis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 21 , 1929, to Nov 22 , 1929, that I last saw h im alive on Nov 22 , 1929 and that death occurred, on the date stated above, at 11-10 P m.

The CAUSE OF DEATH* was as follows:

Acute glomerulo nephritis with uremia

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) none known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Chemical + Physical

(Signed) Chas J Kellin, M. D.

Nov 23 1929 (Address) 2226 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov 26 1929
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 N. North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51319

CERTIFICATE OF DEATH

129 E 51319

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Hamilton Ave. ~~STREET~~ 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia W. Koch

(a) RESIDENCE NO. 2603 Hamilton Ave. ~~XXX~~ WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Koch

6 DATE OF BIRTH (month, day, and year) July 28, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Emil Gail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Fondt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine M. Koch
(Address) 2603 Hamilton Ave.

15 Filed ... 19... C. BAMPSON JONES, M. D.
5 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to November 23 1929 that I last saw h er alive on November 22, 1929 and that death occurred, on the date stated above, at 10.45a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
many years.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
many years.
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

11/25. 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Cemetery — DATE OF BURIAL Nov. 26 1929

20 UNDERTAKER John J. Denny — ADDRESS 715 Light St.

Spec.—1-10-21—M&T—1500 Bks.

Frank Lang

E 51320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51320

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST. 3-5 (WARD) 122

2-FULL NAME Frank Lang or Lang

(a) RESIDENCE No. 109 Albemarle ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 66

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S. A.

PARENTS

10 NAME OF FATHER Henry Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Katherine Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S. A.

14 Informant No Forest Park

(Address)

Filed ..... 19 ..... Registrar

C. H. EMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-5 1929 to 11-25 1929, that I last saw him alive on 11-25 1929, and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Pleurisy with Effusion

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course

(Signed) W. H. Thomas M. D.

19 (Address) 2 Grace & Pine

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York N.Y. DATE OF BURIAL 25 1929

20 UNDERTAKER John C. Miller ADDRESS 2425 E Oliver

25 1929

ATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51321

CERTIFICATE OF DEATH

31 E 51321

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 936 W. Franklin St.) (Ward) 18-26

2-FULL NAME Elsa Berry

(a) RESIDENCE NO. 936 W. Franklin St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Sgl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Aug 5th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Reading
(State or country) Pa

PARENTS

10 NAME OF FATHER Chas Berry

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Lola Artis.

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant
(Address) 936 W. Franklin

15 Filed 19 C. PEMBERTON JONES, M. D. Registrar

25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Otis Media

(duration) yrs. 1 mos. 7 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Smith M. D.

Nov 24th 1929 (Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-25-1929
20 UNDERTAKER Durnell Carter	ADDRESS Govt

important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51322

CERTIFICATE OF DEATH

90 E 51322

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Myrtle St., Ward 17 3)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sommerset Myers

(a) RESIDENCE NO. 1102 Myrtle ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mall	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	-	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Nannie Myers

(Address) 1102 Myrtle ave

15 5 1929, 19 PMr C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from —, 19 27, to Nov. 24, 19 29, that I last saw him alive on Nov. 22, 19 29 and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anthrax (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Doran, M. D.

, 19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lurley Calvert Co Md	11-25 1929
20 UNDERTAKER Daniel Earley	ADDRESS 96 E Pr ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51323

CERTIFICATE OF DEATH

74-001 E 51323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 504 W. Barre St. 27-30 (Ward)

2-FULL NAME Joseph M. McCarthy

(a) RESIDENCE NO. 504 W. Barre St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11-1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Helper
(b) General nature of industry, business, or establishment in which employed (or employer) 029
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alexander McCarthy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary McWilliams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Margaret Murphy
(Address) 335 Scott St

15 Filed 25 1929 19 C. HAMPSON JONES, M. D. Registrar

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Keller, M. D.

11/25 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. National Cem

DATE OF BURIAL 11/27 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Catonsville

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 51324 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 90 E 51324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 N. Fulton Ave St. 16-22 WARD)

2-FULL NAME William C. Moszner.

(a) RESIDENCE. No. 1134 N Fulton Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daisy S. Moszner

6 DATE OF BIRTH (month, day, and year): June 16-1875

7 AGE: Years 54 Months Days If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Rail Road

(c) Name of employer: B & O.

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: John Moszner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore.

12 MAIDEN NAME OF MOTHER: Annie Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mary D. Brown
(Address) 1134 N. Fulton Ave

15 Filed: NOV 25 1929 Registrar: C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 20th 1929 to Nov 23 1929 that I last saw h.. alive on Nov 23 1929 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerative colitis.
(origin undetermined)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) hypo cordial degen

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Relay Md.

Did an operation precede death? no. Date of

Was there an autopsy?

What test confirmed diagnosis? Proctoscopic exam.

(Signed) W. Michel M. D.

Nov 25 1929 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Crm

DATE OF BURIAL: 11/27 1929

20 UNDERTAKER: Robert Brookfield Son

ADDRESS: Baltimore Md

TION is very important. See instructions on back of certificates.

2 5 1929

Spec.—1-12-23—M&T—500 Bks.

E 51325

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51325

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1539 Leslie St. (Ward) 15-21

2-FULL NAME Evelyn Watkins

(a) RESIDENCE No. 1539 Lesley St, WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11, 1924

7 AGE Years 5 Months 7 Days 13 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harrison Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harrison Watkins (Address) 1539 Leslie St.

15 Filed 2 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24 19 29

17 I HEREBY CERTIFY, That I attended deceased from 11/20, 19 29, to 11/24, 19 29, that I last saw h alive on 11/24, 19 29, and that death occurred, on the date stated above, at 6 30 P m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/26 19 29 (Address) 2/29 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremated Md Cheney Sta. Md,

DATE OF BURIAL Nov. 26, 29.

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1303 Pressman St

Spec.—8-16-29—L. F. S.—100 Blks.

Dr Penny 910 N Lombard St Cal 4950

E 51326 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51326

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 S. Arlington Ave ST., 18-29 WARD)

2—FULL NAME Elizabeth Thomas

(a) RESIDENCE NO. 34 S Arlington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Thomas

6 DATE OF BIRTH (month, day, and year) Jan 23, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66	56	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Thomas

(Address) 34 S Arlington Ave

15 Filed 25 1929 C. HUMBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/8/29, 19..., to 11/23/29, 19..., that I last saw h[illegible] alive on 11/23/29, 19..., and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy 6 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard Penny, M. D.

11/25/1929 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 11/26 1929

20 UNDERTAKER [illegible] — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51327

CERTIFICATE OF DEATH

49 E 51327

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto. City Hosp. ST. 16-37 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Kress

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (h) HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Kress

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record

(Address)

Dec 5 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-29

17 I HEREBY CERTIFY, That I attended deceased from 11-1, 1929, to 11-24, 1929

that I last saw h alive on 11-24, 1929

and that death occurred, on the date stated above, at 11³⁰ a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma penereas

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Lusznski, M. D.

11-26, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 11/27 1929

UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Hamilton 44

E 51328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5402 Pembroke ST. 27 43 WARD

2—FULL NAME Frances L Pierce

(a) RESIDENCE NO. 5402 Pembroke Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Pierce

6 DATE OF BIRTH (month, day, and year): March 17 1889

7 AGE: Years 49 | Months 8 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): York Co Pa

PARENTS

10 NAME OF FATHER: Benjamin Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Susan Crum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

14 Informant: Mr Harry Pierce

(Address) 5402 Pembroke Ave

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to Nov 23, 1929 that I last saw h alive on Nov 23 1929 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J Baker, M. D.

11-29-29 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: Nov 27 1929

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51329

CERTIFICATE OF DEATH.

188 1/03

E 51329

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hos. St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Marburger Downey Sr.

(a) RESIDENCE NO. 2509 Maryland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zobedia T. Downey

6 DATE OF BIRTH (month, day, and year) July 9, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
46	46	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Estimator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Simpson & Voeller

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Saml. K. P. Downey

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Elinor Marburger

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs. Zobedia Downey Sr.

(Address) 2509 Maryland Ave.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Ruh into Traffic signal

&c.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Mandible (C.E.)

Fract L. Ilium (duration) yrs. mos. ds.

(Signed) J. J. Traine M. D.

(Coroner)

11 Nov. 19 29 (Address) 2936 Mc Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Preston and Linford

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. Date of Burial Nov. 26 29

20 UNDERTAKER Wm. Hickner & Sons ADDRESS North & Pa

Very Important. See instructions on back of Certificate.

Spec.—1-12-23—M&T—500 Blks.

E 51330 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51330

CERTIFICATE OF DEATH

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) (WARD)

2-FULL NAME Mrs. Mary Falkowich

(a) RESIDENCE NO. 4729 Beaufort Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Falkowich

6 DATE OF BIRTH (month, day, and year): July 8-1880

7 AGE: Years 49 Months 4 Days 17 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Jacob Falkowich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Jennette —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Bertha Falkowich (Wife)

(Address) 4729 Beaufort Ave.

15 Filed NOV 26 1929 19 HEALTH DEPT. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1929. to Nov. 25, 1929.

that I last saw him alive on Nov. 25, 1929.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic glomerulo-nephritis

Chronic Edema heart disease

(duration) > yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical, Laboratory

(Signed) J. Katagna, M. D.

, 19 (Address) W. Balto. Jan. 1930.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herring Run — DATE OF BURIAL: 11-26-1929

20 UNDERTAKER: Jack Lewis, 1439 E. Balto. — ADDRESS

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51331

CERTIFICATE OF DEATH

101-001

E 51331

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Univ Mem. Hospital 4-28 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Scholliam

(a) RESIDENCE NO. 1809 Lemmon St. Balto. Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16, 1928.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	1	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, bnsiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Robt. J. Scholliam

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Brooklyn, N. Y.

12 MAIDEN NAME OF MOTHER Catherine Handy.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Steelton Pa

14 Informant Mrs. Scholliam
(Address) 1809 Lemmon St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to Nov. 24, 1929, that I last saw h[illegible] alive on Nov. 24, 1929 and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

malnutrition (with secondary anemia)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia (right upper), paravesicular, bilateral otitis media

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes + autopsy

What test confirmed diagnosis? X-Ray & physical findings

(Signed) W K Swartzwelder, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/26/29
20 UNDERTAKER	ADDRESS
Geo A Farley Fulton	Laurel

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

2E 57348

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 51332

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Costan

(a) RESIDENCE NO. 427 Acquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Costan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N W 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Handy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Violet Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed [illegible], 19[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 22, 1929, that I last saw h[illegible] alive on Nov 22, 1929 and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

Carcinoma of left lung (? Primary)

(duration) ? 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) =

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Can't say

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special tests.

(Signed) James Bordley, M. D.

Nov. 22 1929 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Z. I. Zion Cem

DATE OF BURIAL Nov. 26 1929

20 UNDERTAKER Mrs C. J. Locke

ADDRESS 1802 Eff[illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

E 51333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

152 E 51333

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 33 E Montgomery St. WARD) 27-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christoph Sr Dederer

(a) RESIDENCE NO. 33 E Montgomery ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Dederer

6 DATE OF BIRTH (month, day, and year) Dec 4 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John M Dederer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Diez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Dederer

(Address) 33 E Montgomery St

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-29

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2 - , 1929, to Nov. 24, 1929, that I last saw him alive on Nov 24, 1929 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? —

(Signed) Irving Miller, M. D.

Nov 26 1929 (Address) 108 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls. Druid Hill Pk	11-27 1929
20 UNDERTAKER	ADDRESS
Mrs Thos A Pohle	2371 Edmondson

Spec.—1-12-23—M&T—500 Blks.

E 51334 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 51334

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6215 Belair Road ST., 26-42 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Edward J. and Evelyn A. Rossiter

(a) RESIDENCE NO. 6215 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24th 1929

7 AGE — Years — Months — Days — If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward J. Rossiter

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Evelyn A. Vollmer

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Edward J. Rossiter (Address) 6215 Belair Rd.

15 Filed ..... 19 ..... Registrar

DEC 6 1929

G. HAMPTON MOUS, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 1929 to Nov 25 1929

that I last saw h[illegible] alive on Nov. 25 1929

and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Premature Child.

Lived 7 hours.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G. Webster M. D.

11/25/29 (Address) 6409 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov. 26 1929

20 UNDERTAKER: Frederick Lasselle Weber — ADDRESS: Fulton

Spec.—2-29-28—L. F. S.—500 Bks.

E 51335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51335

CERTIFICATE OF DEATH

100-00

1—PLACE OF DEATH

REGISTERED NO. 1-1

CITY OF BALTIMORE: (No. 921 S. Linwood Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ROSE E. SINCLAIR

(a) RESIDENCE NO. 921 S. Linwood Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Sinclair

6 DATE OF BIRTH (month, day, and year) January 12, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ruben Jubb

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mrs. Margaret Jackson (Daughter)
(Address) 921 S. Linwood Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 24, 1929, that I last saw h alive on Nov. 24 -, 1929 and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Generalized arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Dowden, M. D.

, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 28. 1929
20 UNDERTAKER Henry Sander & Sons, Inc.	ADDRESS Baltimore & Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

Phone Dec 2 29

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51336 49 E 51336

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Keating

(a) RESIDENCE NO. 2426 Guilford ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Keating

6 DATE OF BIRTH (month, day, and year) ~~1888~~ July 23/89

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Christine Baroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Nov. 25, 1929, that I last saw him alive on Nov. 25, 1929 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Mediastinal tumor with atelectasis of left lung with secondary infection.

(duration) Unknown mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature], M. D.

11-25-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL London Park Cem.

DATE OF BURIAL Nov 27 1929

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1422 Light

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51337

CERTIFICATE OF DEATH

129 ✓ E 51337

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 15-25 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Evans

(a) RESIDENCE NO. 1348 N. Carey ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Evans

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day's work Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Robert Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Hannah Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of
(Address) Baltimore City Hospitals

15 Filed 2 6 1929, 19 C. HAMILTON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 19 29, to Nov. 21, 19 29, that I last saw her alive on Nov. 21, 19 29 and that death occurred, on the date stated above, at 12:45 Am.

The CAUSE OF DEATH* was as follows:

Pt. has this chronic I. cystitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hypertonic Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Wass. & C. Lab. N.Y.

(Signed) Harris M. McClean, M. D.

11-21, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Nov 26 19 29

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pierstmont St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51338

100-001

E 51338

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. Baltimore City Hosp, ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sherman Horne

(a) RESIDENCE NO. 1032 Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Daniel Horne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address) JOHNS HOPKINS HOSP.

15 Filed 29 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-29

17 I HEREBY CERTIFY, That I attended deceased from 5-7, 1929, to 11-24, 1929

that I last saw h/im alive on 11-24, 1929

and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Perineal urinary fistula

following prostatectomy

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp.

Did an operation precede death? Yes Date of Unknown

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Rumpstein, M. D.

11-29, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williams Port, Pa.

DATE OF BURIAL 11-26, 1929

20 UNDERTAKER Dennis Eaton

ADDRESS 916 Pa ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51339

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 51339

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hosp

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 200 N Calvert ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Edward Ross

(a) RESIDENCE NO. 333 E 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
- 77	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton md

14 Informant Mercy Hosp.

(Address)

15 Filed 11 26 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25-1929

17

I HEREBY CERTIFY, That I attended deceased from November 25, 1929, to November 25, 1929, that I last saw h.. alive on November 25, 1929 and that death occurred, on the date stated above, at 8 16 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertensive Cardio Vascular Disease (duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? none

(Signed) Dr Rose Nestadt, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md — DATE OF BURIAL 11-26 1929

20 UNDERTAKER Daniel Easton — ADDRESS 916 Bo ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51340 E 51340

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S. Curley ST. 1-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry H. Quigley.

(a) RESIDENCE No. 606 S Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Mar. Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Quigley.

6 DATE OF BIRTH (month, day, and year) May 31-1887

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	42 43	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Enamel Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Emory Quigley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary Gormley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Mary Quigley (Address) 606 S Curley St

15 Filed NOV 28 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1929 to Nov 25 1929, that I last saw h alive on Nov 23 1929, and that death occurred, on the date stated above, at 11.20 a m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Lues -

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) General paresis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V Bucholtz M. D.

Nov 25, 1929 (Address) 37 S Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL Nov 27 1929

20 UNDERTAKER Geo M. Fouke & Son

ADDRESS 811 N Wolfe

Spec.—8-16-29—L. F. S.—100 Bks.

E 51341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 51341

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 E. 27th St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma L. Mettee

(a) RESIDENCE NO. 607 E. 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William H. Mettee

6 DATE OF BIRTH (month, day, and year) September 17th 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Reuben Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Rebecca Bayley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Mary E. Murgatroyd

(Address) 607 E 27th St

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25th 1929

17

I HEREBY CERTIFY, That I attended deceased from January 16th, 1927, to Nov 25th, 1929, that I last saw h[illegible] alive on Nov 25th, 1929 and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTOR (Secondary) Senile Dementia

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Augustus Magruder M. D.

11/25 1929 (Address) 40 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov. 28 1929
20 UNDERTAKER	ADDRESS
Henry Hough Sons, Inc	1301 E Eager St

DEC 2 6 1929 HAMPSON JONES M

Spec.—8-16-29—L. F. S.—100 Bks.

E 51342

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51342

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 16-29

CITY OF BALTIMORE: (No. 614 N Monroe ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Zahn

(a) RESIDENCE NO. 614 N Monroe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edwin L Zahn

6 DATE OF BIRTH (month, day, and year) Oct 19 55

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo Lear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Lillian Zahn
(Address) 614 N Monroe St

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1926, to Nov 23 1929, that I last saw her alive on Nov 23 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil H. Zahn, M. D.

11/25, 1929 (Address) 3005 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Md	Nov 26 1929
20 UNDERTAKER	ADDRESS
W M Rountree	2238 N Mtn Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51343

CERTIFICATE OF DEATH

90 ✓ E 51343

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1920 East 31st ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Emrich

(a) RESIDENCE NO. 1920 East 31st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 10 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

(a) If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of: Wilhelmina Emrich

6 DATE OF BIRTH (month, day, and year): Dec. 28. 1849

7 AGE: Years 79 | Months 10 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick Emrich

(Address): 1920 East 31st 1929

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 19 29, to Nov 23, 19 29

that I last saw h~~im~~ alive on Nov. 23, 19 29

and that death occurred, on the date stated above, at 10-30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chr. Bronchitis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed ~~diagnosis~~? Physical Exam

(Signed) Paul Brown, M. D.

10 24 19 29 (Address) 1663 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paula Violetville Md

DATE OF BURIAL: 11/27/1929

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51344

CERTIFICATE OF DEATH

105 E 51344

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospital St. 6-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Goldberg

(a) **RESIDENCE NO.** 2124 Orleans St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ethel Goldberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Book-Binder
(b) General nature of industry, business, or establishment in which employed (or employer) 064
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Harry Goldberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER
Bessie ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto. St.

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) inquiry find that said deceased came to d1S death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

11/20/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	11-26 1929
20 UNDERTAKER	ADDRESS
Joe Lewis, 1439 E. Balto	

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51345

CERTIFICATE OF DEATH

E 51345

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 Orleans ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Wm Bishop Jr

(a) RESIDENCE NO. 946 N. Chester St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 27/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Wm Bishop Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Kenley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Wm Bishop Sr.

(Address) 2800 Orleans St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24/29

17 I HEREBY CERTIFY That I attended deceased from Nov 23, 1929, to Nov 24, 1929, that I last saw h[illegible] alive on Nov 24, 1929 and that death occurred, on the date stated above, at 11 1/2 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Single)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Rypien M. D.

Nov. 25 1929 (Address) 801 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Nov 27 1929

20 UNDERTAKER Philip Herwig

ADDRESS 2216 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 51346

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2512 E Hoffman ST., 8-16 WARD)

2—FULL NAME Charles C Otto.

(a) RESIDENCE NO. 2512 E. Hoffman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 30 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School. Pupil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas M. Otto.

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lind.

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Chas M. Otto.
(Address) 2517 E. Hoffman

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to Nov. 23, 1929
that I last saw h wife alive on Nov. 23, 1929.
and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis
Hypertention
Mitral Regurgitation (Accompensated)
(duration) yrs. 4 mos. 19 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation
(duration) yrs. 4 mos. 19 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Thos F Stevens, M. D.

11/25/1929 (Address) 1878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL Nov 26 1929

20 UNDERTAKER Philip Herwig ADDRESS 1016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

V-001-101

E 51347

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 693 W Mulberry ST. 425 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene J Cook

(a) RESIDENCE NO. 693 W Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Jan 9. 1900

7 AGE — Years: 29 — Months: 10 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Remus Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Maryland

12 MAIDEN NAME OF MOTHER: Emma Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: William Cook

(Address) 693 W Mulberry Street

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 1929 to Nov 24 1929 that I last saw h alive on Nov 23 1929 and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Cedar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Cedar, M. D.

19 (Address) 1 S Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Lion — DATE OF BURIAL: Nov. 26 1929

20 UNDERTAKER: Joseph A. Lively — ADDRESS: 409 N Mount St

Spec.—2-29-28—L. F. S.—500 Blks.

03196 E 51348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 51348

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME VICTOR HUGO

(a) RESIDENCE NO. 19 E - Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary

6 DATE OF BIRTH (month, day, and year) 1/14/81

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Nov 25, 1929, that I last saw him alive on Nov 25, 1929 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia secondary to carcinoma of lung.

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Ca of lung

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray

(Signed) Oskar Diethelm, M. D.

11-27, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	11/27 1929
20 UNDERTAKER Henry W. Mears and Son	ADDRESS 405 N. Calvert

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51349

CERTIFICATE OF DEATH

1/12 E 51349

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 211 N. Amity ST. 18-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerome Robinson

(a) RESIDENCE NO. 211 N. Amity ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 3 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Robinson

6 DATE OF BIRTH (month, day, and year): July 8, 1882

7 AGE: Years 47 Months 3 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Geo Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie E. Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Annie Robinson

(Address) 211 N. Amity

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-23-29

17 I HEREBY CERTIFY, That I attended deceased from 11-21, 1929, to 11-23, 1929, that I last saw h[illegible] alive on 11-23, 1929 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Macco Williams, M. D.

11-25, 1929 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Nov. 26, 1929

20 UNDERTAKER: Mrs. Kottie R. Williams

ADDRESS 3221 Echodale Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 51350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-001 E 51350

1—PLACE OF DEATH Baltimore City Hospitals (T.B. 8-13) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlie Butler

(a) RESIDENCE NO. 1603 E. Ellworth st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Reid Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sarah Berge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

C. H. EDMONDSON, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1929, to Nov. 23, 1929, that I last saw him alive on Nov. 23, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pleurisy + Effusion

(duration) yrs. 3 mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jas. G. Lemmon M. D.

11-23-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Nov. 26 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Oakland

Spec.—2-29-28—L. P. S.—500 Blks.

E 5135P

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 5135P

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 118 N. Washington ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Bamberger

(a) RESIDENCE NO. 118 N. Washington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nettie Bamberger

6 DATE OF BIRTH (month, day, and year): March 23 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Casper Bamberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mrs. Nettie Bamberger
(Address) 118 N. Washington St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-24-29

17

I HEREBY CERTIFY, That I attended deceased from 10-1, 1929, to 11-24, 1929, that I last saw h[illegible] alive on 11-24, 1929, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 10—29

Was there an autopsy?

What test confirmed diagnosis? X-ray & Clinical Symptoms

(Signed) ... M. D.

11-25-29 (Address) 800 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 27 1929
20 UNDERTAKER	ADDRESS
Jos. F. Kerr	156 N. Luzerne

Cor.—10-10-29—A Co.—100 Bks.

Laster

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51352

CERTIFICATE OF DEATH

19 8 ✓ E 51352

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5-13 Mount St. 4-27 Ward)

2-FULL NAME John H Laster

(a) RESIDENCE NO. 5-13 Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Mal	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sohn Laster

6 DATE OF BIRTH (month, day, and year) Sept 25th 1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Sophia Laster
(Address) 513 N Mount

15 Filed ..... 19.. HAMILTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach trouble
Hemorrhage, Lung
Stabbed wound Lung
Left Hand (duration) Shortly yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

Nov 25 1925 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Nov 28th 1925

20 UNDERTAKER A. Jones — ADDRESS 1161 Gilmor

Spec.—2-29-28—L. F. S.—500 Blks.

E 51353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51353

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 21-31 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Camper

(a) RESIDENCE NO. 512 W. Cross ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Silver Washer

(b) General nature of industry, business, or establishment in which employed (or employer): 0.6

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Stephen Camper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of
(Address): Balto. City Hosp.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 19 29 to Nov. 22, 19 29, that I last saw him alive on Nov. 22, 19 29 and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Toxic

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist: H.C: X-ray: Autopsy

(Signed) Harvey W. McCleave M. D.

11-26. 19 29 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: 11-27 19 29

20 UNDERTAKER: Byron Wright ADDRESS: 218 McCulloh St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51354

CERTIFICATE OF DEATH.

44 E 51354

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3800 Claremont Ave ST. 16-37 WARD

2-FULL NAME Joseph Aiello

(a) RESIDENCE NO. 3800 Claremont Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 25 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dominica Aiello

6 DATE OF BIRTH (month, day, and year): July 12, 1874

7 AGE: Years 55 Months 4 Days 13 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Pietro Aiello

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Maria Esposito

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Frank Aiello
(Address) 713 N. Kenwood

15 Filed ..... 19 ..... Registrar

E. H. [illegible] M. D.

NOV 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. ..., 19 29, to Nov. 25 ..., 19 29, that I last saw him alive on Nov. 25th ..., 19 29, and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

(duration) 2 1 yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary): acute Broncho Pneumonia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct - 1929

Was there an autopsy? No

What test confirmed diagnosis? Pathological Specimen from Morrow

(Signed) Morrow J. Jr. Eindlich, M. D.

, 19 (Address) 1515 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 28 1929

20 UNDERTAKER: Frank V. Petrone — ADDRESS 2815 E. Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

E 51355

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 51355

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Rozinski

(a) RESIDENCE NO. 603 S. Wolfe ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ?yrs. ?mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catharine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62 or 63 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Ot

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Marcella Rozinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catharina ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed 2 6 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 19 29 to Nov. 25, 19 29

that I last saw him alive on Nov. 25, 19 29

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Infectious

(duration) over yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema, Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. Path. Lab

(Signed) Marvin M. McClain, M. D.

11-25, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Nov 28 —	19 29
20 UNDERTAKER	ADDRESS
E W Krazewski 930	Eastern Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 51356

HEALTH DEPARTMENT—CITY OF BALTIMORE

167-001 ✓ E 51356

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 45 S. Robinson ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Jones

(a) RESIDENCE NO. 45 S. Robinson ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Farley Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Dora Hanson

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Farley Jones

(Address) 45 S. Robinson St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1929, to Nov. 25, 1929, that I last saw h. alive on Nov. 25, 1929 and that death occurred, on the date stated above, at 7 15 m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ months)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatorum

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel B. Wolfe, M. D.

11/25, 1929 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 26 19
20 UNDERTAKER	ADDRESS
Ely & Zeborowski	40 E. Oliver

NOV 26 1929 E. HARRISON JONES, M.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51357

CERTIFICATE OF DEATH

129 ✓

1—PLACE OF DEATH

REGISTERED NO. E 51357

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 525 S. Ann ST. 2-4 WARD)

2—FULL NAME Louise Janusch

(a) RESIDENCE NO. 525 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles L. Janusch

6 DATE OF BIRTH (month, day, and year): May 9 1852

7 AGE: Years 77 | Months 6 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Michael Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma M. Wiesinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John L. Janusch

(Address): 525 S. Ann St.

15 Filed 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 25- 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4- 1929, to Nov. 25- 1929, that I last saw h[illegible] alive on Nov. 25- 1929 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) 5- yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Fleming, M. D.

Nov 26, 1929 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: Nov 28 1929

20 UNDERTAKER: Louis Heemann

ADDRESS: 32 S. Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51358 — CERTIFICATE OF DEATH — 89 — E 51358

1—PLACE OF DEATH — REGISTERED NO. 562

CITY OF BALTIMORE: (No. 3623 Wabash Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry S Herman

(a) RESIDENCE NO. 3623 Wabash ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70		1918	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co (State or country) Md

PARENTS

10 NAME OF FATHER William S Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Wooden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Mary R Herman
(Address) 3623 Wabash ave

15 Filed 26 1929 19 C. H. IMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24th P M

17 I HEREBY CERTIFY, That I attended deceased from Nov 23rd a m, 1929, to Nov 24th P M, 1929, that I last saw h.im alive on Nov 24th, 1929 and that death occurred, on the date stated above, at 10-30 P. m.

The CAUSE OF DEATH* was as follows:

angina Pectoris

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Eugene Douglas, M. D.

, 19 (Address) 3043 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Nov 27 1929

20 UNDERTAKER George F Smith — ADDRESS 1537 Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

E 51359 HEALTH DEPARTMENT—CITY OF BALTIMORE

Note

CERTIFICATE OF DEATH.

161-60 E 51359

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 W Fayette St. 18 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Baby Queen

(a) Residence No. 921 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Negro

5-Single, ✓ Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 13 1929

7-AGE. ....yrs. ....mos. 10 ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Baltimore Md. (State or Country).

PARENTS.

10-NAME OF FATHER, John Queen

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country).

12-MAIDEN NAME OF MOTHER, Pearl Harris

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country).

14-

(Informant)

(Address)

15-

Filed ....., 19.., ..., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 23 1929

17- I HEREBY CERTIFY, That I attended deceased from Nov 13, 1929 to Nov 23, 1929 that I last saw him alive on Nov 22 1929 and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

New born infant (Premature)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Daniel F. [illegible] M. D

, 1929 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
	....., 19..
20-UNDERTAKER. Commissioner Health.	ADDRESS. NOV 26 1929

UNIVERSITY OF MARYLAND

12-23-29 C. HARRISON JONES M.....

4107, RPH

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51360 2

CERTIFICATE OF DEATH

11-002 E 51360

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Curtis

(a) RESIDENCE NO. St Elizabeths Home ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Ben Brown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Helen Curtis

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 .....

C. HAMPSON JONES
Registrar

4101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 25, 1929, that I last saw h[illegible] alive on Nov 25, 1929 and that death occurred, on the date stated above, at 1 15 A m.

The CAUSE OF DEATH* was as follows:

Influenza meningitis
(B influenza isolated from spinal fluid)

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Eliz. Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Spinal fluid culture

(Signed) L. C. Goodpasture, M. D.

11/25, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Saicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 26 1929

20 UNDERTAKER	ADDRESS
Commissioner Health	

Spec.—2-29-28—L. F. S.—500 Bks.

930 626 E 51361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16 1-001 E 51361

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Butler

(a) RESIDENCE NO. 134 E. East St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/28/29

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliz - Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 26 1929 4100 mm C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Nov. 23, 1929, that I last saw her alive on Nov. 23, 1929, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? State Autopsical

What test confirmed diagnosis?

(Signed) J. W. Bickford Jr, M. D.

11/25, 1929 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner

ADDRESS

NOV 26 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 51362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51362

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 Calloway Ave. ST. 15-6-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Tilghman Hollyday

(a) RESIDENCE NO. 3402 Calloway Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lena Dorothy Hollyday

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	55	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. T. Hollyday

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Alexina Chamberlain

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Lena Dorothy Hollyday
(Address) 3402 Calloway Ave.

15 Filed 2 6 1929 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-25-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20. 1929, to Nov. 24, 1929, that I last saw him alive on Nov. 24, 1929 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis
Hypocondritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jules S. Bishop, M. D.

19 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 28 1929

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 51363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001 V E 51363

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 817 Greenmount Ave. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas McEachern

(a) RESIDENCE NO. 817 Greenmount Ave ST., WARD north Carolina
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie McEachern

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&P

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electric Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Fayettville (State or country) N. C

PARENTS

10 NAME OF FATHER Milton McEachern

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Phebie Pickens

13 BIRTHPLACE OF MOTHER (city or town) Wilson Co (State or country) N. C

14 Informant Hattie McEachern
(Address) 817 Greenmount Ave

15 Filed 12 6 1929, 19 H. AMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-29

17 I HEREBY CERTIFY, That I attended deceased from 11/21, 1929, to 11/24, 1929, that I last saw him alive on 11/24, 1929, and that death occurred, on the date stated above, at 2:25 p. m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

11/26, 1929 (Address) 733 Ausquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fayettevill N. C.	11-27 1929

20 UNDERTAKER Byrom & Wright ADDRESS 218 McElderry St

Spec.—12 9 25—A Co.—200 Blks.

E 51365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 51364

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2417 Greenmount Ave St. 46 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Jennie M. Gildenfenney.

(a) RESIDENCE NO. 2417 Greenmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of J. H. Gildenfenney

6 DATE OF BIRTH (month, day, and year) May 16 1870.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Iowa.

PARENTS

10 NAME OF FATHER W. H. Anderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER Sarah V. Hill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant L. Barry Gildenfenney

(Address) 2417 Greenmount Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

Rec'd 26 1929 Pat. 8011

very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 - 1929 19

17

I HEREBY CERTIFY, That I attended deceased from July 1 1929, to Nov 23, 1929, that I last saw h[illegible] alive on Nov 22, 1929, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris 1

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Lennard, M. D.

11/26, 1929 (Address) 718 N Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 11/27 1929

20 UNDERTAKER Liston P. Fassett ADDRESS 2628 St Paul.

Cor.—10-10-29—A Co.—100 Bks.

E 51365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 51365

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1330 Aisquith St. 9-16 Ward)

2-FULL NAME John Kirwan

(a) RESIDENCE NO. 1330 Aisquith St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Annie Kirwan

6 DATE OF BIRTH (month, day, and year) Nov 25/1851

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	78	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Formerly Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Stationary Engine
(c) Name of employer 630

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Peter Kirwan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Duffy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Margaret Ward
(Address) 1330 Aisquith St

12 6 1929 C. HAMPSON JONES, M. D., Registrar

Dur ncd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Erysipelatous Infection of
Lacerated wound of left knee.
Accidentally fell on street

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Somewhere on st

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Kates, M. D.

1/26 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov 27 1929

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Greenmount Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Mary O. Hamilton ✓

E 51366

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51366

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 213 S. Gilmor St. ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary O. Hamilton

(a) RESIDENCE NO. 213 S. Gilmor St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Hamilton

6 DATE OF BIRTH (month, day, and year) August 29, 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Charles Hamilton

(Address) 213 S. Gilmor St.

15 Filed 12 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/29

17

I HEREBY CERTIFY, That I attended deceased from 11/1/29, 19, to 11/24/29, 19,

that I last saw her alive on 11/24/29, 19

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chr Diff. Neph.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) Bernard J. Terry, M. D.

11/26/29 (Address) 9 0 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 27 1929
20 UNDERTAKER Terry & Twitchell, 5310	ADDRESS Lombard St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90. E 51367

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 S. Calhoun ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Wesley Farriman

(a) RESIDENCE NO. 124 S. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Fanny Elizabeth Farriman

6 DATE OF BIRTH (month, day, and year) Dec 6-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	36	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work District manager

(b) General nature of industry, business, or establishment in which employed (or employer) Newspapers.

(c) Name of employer Post.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frank Willard Farriman

11 BIRTHPLACE OF FATHER (city or town) Albany.
(State or country) New York.

12 MAIDEN NAME OF MOTHER Elizabeth Jane Webb

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Wales

14 Informant Elizabeth J. Farriman
(Address) 1602 W. Baltimore St.

15 Filed 2 6 1929, 19 [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-29.

17 I HEREBY CERTIFY, That I attended deceased from July 18-, 1929, to November 25-, 19--, that I last saw him alive on November 24, 19--, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Richards, M. D.

11-25-, 1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 11.28 1929

UNDERTAKER Harry V. Lutzke. 1531/4

ADDRESS Homeland

Spec.—1-12-23—M&T—500 Blks.

51328

E 51368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE ~~OF DEATH~~.

E 51368

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. 70 69 S. W. (WARD) 118

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva M Snyder

(a) RESIDENCE No. 512 East Lynn Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 39 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of William Snyder

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER August Straub

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Lumpman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William J. Snyder
(Address) 512 East Lynn Ave

15 Filed 2 6 1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1929, to Nov. 25, 1929, that I last saw her alive on Nov. 25, 1929, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 20. 29

Was there an autopsy? No

What test confirmed diagnosis? Expert Evidence

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov. 29 1929

20 UNDERTAKER Harry N. Weitzel, 15 31 W — ADDRESS Lombard St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51369

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 W University Pkwy) (St. Paul Sts.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry L Bowman

(a) RESIDENCE NO. 100 W. University Parkway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, ~~Widowed, or Divorced, (write the word)~~: Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie K Bowman

6 DATE OF BIRTH (month, day, and year): Oct 28-1842

7 AGE: Years 87 | Months — | Days 27 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Catherine Pick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Chas D. Bowman

(Address): 100 W University Pkwy

15 Filed: 2 6 1929, 19..., C. HAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Nov 25, 1929, that I last saw h immalive on Nov 25, 1929, and that death occurred, on the date stated above, at 7.55 P.M.

The CAUSE OF DEATH* was as follows: Cystitis Interstitial Chronic

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Uremic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? - -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. C. Lemmon, M. D.

Nov 26, 1929 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Woodlawn Cem't — DATE OF BURIAL: Nov 27 1929

20 UNDERTAKER: Bertram & Poe — ADDRESS: 1723 W. Lafayette Ave

Spec.—1-10-21—M&T 1500 Bks.

E 51370

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51370

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Kernan Hospital (Street) 28-65 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund C. Haupt.

(a) RESIDENCE NO. Myersville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Myersville, Md.

PARENTS

10 NAME OF FATHER Columbus Haupt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Anna Flook

13 BIRTHPLACE OF MOTHER (city or town) Myersville Md (State or country)

14 Informant Anne Houck (Address) Myersville Md

15 Filed 12 6 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26- 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, to Nov. 26, 1929, that I last saw him alive on Nov. 26, 1929, and that death occurred, on the date stated above, at 2:55 P m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis (Septicemia)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 11-7-29

Was there an autopsy? No

What test confirmed diagnosis? X-ray + Blood Culture

(Signed) Joseph L. Benzaquin, M. D.

, 19 (Address) Kernan Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Myersville Md DATE OF BURIAL Nov 28 1929

20 UNDERTAKER E. K. Gladhill ADDRESS Middletown

ATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 51371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 ✓ E 51371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3739 Roland Ave ST. 3-52 WARD)

2-FULL NAME Sarah Wyatt Reynolds.

(a) RESIDENCE No. 3739 Roland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Whit	Widowed

5a If married, widowed, or divorced (or) WIFE of Robt. F Reynolds

6 DATE OF BIRTH (month, day, and year) Dec 11-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. N. Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine McIntosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) 3739 Fall Rd

15 Filed 12 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2nd 1928 to Nov. 25 1929.

that I last saw her alive on Nov. 25th 1929,

and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 1 mos 23 ds.

CONTRIBUTORY (Secondary) Abdominal Metastasis.

(duration) 1 yrs. 1 mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Oct. 2nd 28

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Exam

(Signed) J. Mason Hundley M. D.

, 19 (Address) Medical Arts Bldg. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park | DATE OF BURIAL Nov 27 1929

UNDERTAKER A. D. Marshall | ADDRESS 3539 Fall Rd

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

33 ✓

E 51372

E 51372 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 Mosher St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Mae Keen

(a) RESIDENCE NO. 427 Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 19 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 6- 25

7 AGE — Years: 4 — Months: 1 — Days: 19 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Louis Keen

11 BIRTHPLACE OF FATHER (City or town) (State or country): Cambridge Md

12 MAIDEN NAME OF MOTHER: Maggie Tinsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md

14 Informant: Maggie Keen (Address) 427 Mosher

15 Filed NOV 27 1929 C. HAMPSON JONES, M. D. Registrar

Per RMC.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-25-29 19

17 I HEREBY CERTIFY, That I attended deceased from 10/7/29, 19..., to 11/24/29, 19..., that I last saw h[illegible] alive on 11-24-, 19 29, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Tabes Mesenterica

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Bronchitis and

Enlarged Tonsils (duration) ... yrs. 2½ mos. ... da.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M Boyle, M. D.

11-26 1929 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dove — Date of Burial: Nov 29 1929

20 UNDERTAKER: Jam. H. Cleaveland Son — ADDRESS: Hood & Mosher

OF DEATH in plain terms, so that it may be properly classified. Each question is very important. See instructions on back of certificates.

NOV 27 1929

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51373
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

91 Vol 2 E 51373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 22 E Gittings ST. 23-33 WARD)

2-FULL NAME William Wethekamm

(a) RESIDENCE NO. 22 E. Gittings ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Wethekamm

6 DATE OF BIRTH (month, day, and year) July 18th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy

PARENTS
10 NAME OF FATHER Ludwig Wethekamm
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ.
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Mrs. Bertha Roder
(Address) 1817 Lovington av.

15 Filed Nov 27 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Nov. 24, 1929, that I last saw h. alive on Nov. 24, 1929, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) [illegible] Compton M. D.

Nov. 27, 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Nov 29 1929
20 UNDERTAKER	ADDRESS 1039
E Schloman & Son	Hanover

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51374 ✓ 100-001 E 51374

E 51374

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 613 W. West ST. 21-24 WARD

2-FULL NAME Lena Heim

(a) RESIDENCE NO. 613 W. West ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Heim

6 DATE OF BIRTH (month, day, and year): July 5, 1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant: Mrs. Lillian Knox

(Address) 613 W. West St

Filed 12 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1929, to Nov. 24, 1929, that I last saw h[illegible] alive on Nov 24, 1929, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos indefinite

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) [illegible] M. D.

Nov 28, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL Nov 28 1929

20 UNDERTAKER: E. Schlosman & Son — ADDRESS 1039 Hanover

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

230 190 0 E 51375.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 51375

1—PLACE OF DEATH

REGISTERED NO. 14-27

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Poulton Poulton

(a) RESIDENCE NO. 1603 N. Carey 1432 W. Fayette St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr 8 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/1/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) bd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER John Poulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Virgie Poulton Alberta Mayzyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Parents -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 7 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-25-29

17

I HEREBY CERTIFY That I attended deceased from Oct 19, 1929, to Nov-25, 1929, that I last saw h.... alive on Nov-25, 1929 and that death occurred, on the date stated above, at 3 40 P m.

The CAUSE OF DEATH* was as follows:

Gastro. enteritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. C. Goodwin, M. D.

11/24. 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Nov.27 1929

20 UNDERTAKER [illegible]

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51376

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Chilton St. ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane E. Bower

(a) RESIDENCE NO. 1631 Chilton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ralph Bower

6 DATE OF BIRTH (month, day, and year) May 25 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) England
(State or country)

PARENTS

10 NAME OF FATHER J. Jupp

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. Lomas
(Address) 1631 Chilton St.

15 [illegible] 1929 S. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 29

17 I HEREBY CERTIFY, That I attended deceased from Mar 18 29, 19..., to Mar 25 29, 19...,
that I last saw her alive on Mar 25 29 7 30 P m.
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Internal Hernia)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos R Holt, M. D.

Mar 29 29 (Address) 1203 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 4/28 1929

20 UNDERTAKER J. Fenw McCully

ADDRESS 130 E. Fort

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23392 E 51377

CERTIFICATE OF DEATH

+ 101-001 ✓ E 51377

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sherman S. Johnson

(a) RESIDENCE NO. 425 E. Pennsylvania ST. Towson Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 27 1929 16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-26-29

17 I HEREBY CERTIFY, That I attended deceased from Nov-20, 1929, to Nov 26, 1929, that I last saw him alive on Nov 26, 1929 and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcal septicaemia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia, pneumococcal pneumothorax (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home, Towson

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture of pus from chest cavity.

(Signed) Hedwig Roelig, M. D.

11/29/29 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL National Cemetery — DATE OF BURIAL Nov. 29, 1929

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1715 Ashland Ave

Cor.—10-10-29—A Co.—100 Bks.

E 51378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-1001

E 53858

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2026 Brunt St. (St.) 14-5 (Ward)

2-FULL NAME John T Carey.

(a) RESIDENCE 26 E. Lee Gold & Brunt Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude.

6 DATE OF BIRTH (month, day, and year) 1887-

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unk.

14 Informant Gertrude Carey
(Address) 1822 Parrish

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month) Nov 25 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy
(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

Nov 26 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 29, 29
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1203 Pulaski St

IMPORTANT. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

51379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 51379

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Alley nr 1105 Greenmount St., 10-14 Ward)

2-FULL NAME Millard D. Creech

(a) RESIDENCE NO. 900 E. Biddle St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E. Creech

6 DATE OF BIRTH (month, day, and year) Jany 5/1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penna R.R.

9 BIRTHPLACE (city or town)
(State or country) N.C.

PARENTS

10 NAME OF FATHER Park C. Creech

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Johnston

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Mrs. Mary Creech
(Address) 900 E. Biddle St

15 Filed NOV 2 1929 19 Hobson Jones, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Alcoholism & Exposure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Allen, M. D.

12/20/19[illegible] (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	11/27/1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51380

CERTIFICATE OF DEATH

90 ✓ E 51380

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 8-12 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris Fugate

(a) RESIDENCE NO. 2216 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James P. Fugate

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary C. Barnhardt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed NOV 27 1929 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Nov. 25, 1929, that I last saw h... alive on Nov. 25, 1929 and that death occurred, on the date stated above, at 6 P. M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) over yrs. mos. 36 ds.

CONTRIBUTORY (Secondary) Cerebrosclerosis Arteriosclerosis

(duration) over yrs. mos. 36 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & C. Lab. Autop.

(Signed) Marvin W. McLean, M. D.

Nov. 26, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetary	11/29/1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Blks.

E 51381 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 51381

CERTIFICATE OF DEATH

147

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 436 N. Pulaski ST. 11-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie M. Dakin

(a) RESIDENCE NO. 436 N. Pulaski ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

3a If married, widowed, or divorced (or) WIFE of Elmer Dakin

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Tilghmans Island, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Sinclair

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Caroline M. Miller

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Charles A. Sinclair
(Address) Tilghmans Island

15 Filed 12 7 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-29

17 I HEREBY CERTIFY, That I attended deceased from 11-26, 1929, to 11-26, 1929, that I last saw h[er] alive on 11-26, 1929 and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Coronary embolus

CONTRIBUTORY (Secondary) following delivery of child. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-26-29.

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. Alexander Lowry M. D.

11/26, 1929 (Address) 1516 Medeira Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tilghman Island Cemetery	Nov 28 1929

20 UNDERTAKER Harry A. Amacost ADDRESS 4204 Ridgewood Ave

Spec.—1-12-23—M&T—500 Blks.

John D Bohn

E 51382 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51382

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. 7-4 ST., (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John D Bohn.

(a) RESIDENCE NO. 258 South Ann St. ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sophia Bohn

6 DATE OF BIRTH (month, day, and year) Jan 19th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57	57	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Business

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Bernard H. Bohn

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Meta Sophia Krieg

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Bessie Bohn Wife (Address) 258 S. Ann St.

15 Filed NOV 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-23- , 1929 , to 11-24 , 1929 , that I last saw him alive on 11-24-29 , 19 , and that death occurred, on the date stated above, at 4 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) ? Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon H Norwood, M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Nov. 27 1929

20 UNDERTAKER Lilly & Julian Inc. ADDRESS 403 E. Mosher St

Cor.—10-10-29—A Co.—100 Blks.

E 51383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51383

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 8-16 Ward)

2-FULL NAME William H Mercer

(a) RESIDENCE NO. 2523 E. Hoffman St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary J. Mercer

6 DATE OF BIRTH (month, day, and year) Nov 4/1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	05	0	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter (?)
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Kentucky

PARENTS

10 NAME OF FATHER Matthew Mercer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Effie C. Young

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kentucky

14 Informant Mary J. Mercer
(Address) 2523 E. Hoffman St

15 Filed 1929 19 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said injury (Inquest, autopsy or inquiry) find that said deceased came to HIS death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Kelly, M. D.

1/27/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 29 1929

20 UNDERTAKER George N. Zinkler — ADDRESS 1737 E. Eager St

IMPORTANT. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51384

CERTIFICATE OF DEATH

31 ✓ E 51384

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4209 Woodlea ave ST. 26-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Mae Lebompte

(a) RESIDENCE NO. 4209 Woodlea ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Lebompte

6 DATE OF BIRTH (month, day, and year) July 21-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James R. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elton, Md.

12 MAIDEN NAME OF MOTHER Mary E. Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co. Md.

14 Informant Charles E. Lebompte

(Address) 4209 Woodlea ave.

15 Filed DEC 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26-1929

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Nov 26, 1929, that I last saw h alive on Alive, 19 29 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) [illegible], M. D.

11-7-1929 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL Nov 30 1929

20 UNDERTAKER George W. Zirkle — ADDRESS 1737 E. Eager st

Spec.—2-29-28—L. F. S.—500 Blks.

E 51385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 51385

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 S. Potomac ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia A. Lomax

(a) RESIDENCE NO. 637 S. Potomac ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Silas W. Lomax

6 DATE OF BIRTH (month, day, and year) April 8-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER John T. Goodwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co. Md

12 MAIDEN NAME OF MOTHER Julia Nabbit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co. Md.

14 Informant Augusta M. Metzger

(Address) 637 S. Potomac St

15 Filed NOV 7 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26-1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to 11/26, 1929, that I last saw h. alive on 11/25, 1929 and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C A Reifschneider, M. D.

11/26, 1929 (Address) 2989 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Michaels Md.

DATE OF BURIAL Nov 29 1929

20 UNDERTAKER George W. Zirkle

ADDRESS 1737 E. Eager St

Spec.—1-10-21—M&T—1500 Bks.

E 51336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 51336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2013 Booth ST. 20-28 WARD

2-FULL NAME Andrew S. Eisenbaugh

(a) RESIDENCE NO. 2013 Booth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Eisenbaugh

6 DATE OF BIRTH (month, day, and year): April 17-1859

7 AGE: Years 70 Months 7 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Stone Mason

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Andrew Eisenbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Pa

14 Informant: Mrs. Martha E. Eisenbaugh

(Address) 2013 Booth St

15 Filed NOV 27 1929 19

E. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1929, to November 25, 1929,

that I last saw h. alive on Nov. 25, 1929,

and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 2 hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Hemiplegia (Cerebral Thrombosis)

(duration) yrs mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure

(Signed) Chas A Cohn, M. D.

Nov 29 (Address) 2105 N Belto Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Plain Cemetery — DATE OF BURIAL: Nov. 28 1929

20 UNDERTAKER: George L. Schwab — ADDRESS: 1001 Fredk Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 51387 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 100-00 E 51387

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sinai Hospital ST. 7-1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Knisell

(a) RESIDENCE No. 715 N. Curley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9 - 1928

7 AGE Years 1 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stockton Md

PARENTS

10 NAME OF FATHER Roy R. Knisell

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jer

12 MAIDEN NAME OF MOTHER R. Brittingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stockton Md

14 Informant Sinai Hosp
(Address)

15 Filed NOV 27 1929, 19 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1929, to 11/27, 1929, that I last saw him alive on 11/27, 1929, and that death occurred, on the date stated above, at 2. am.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos 7. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? [illegible] autopsy

(Signed) [illegible] M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hurley Station Md

DATE OF BURIAL Nov. 27 1929

20 UNDERTAKER John C. Miller

ADDRESS 2435 E Alice

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gurevitz

E 51388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 51388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 27-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Gurevitz

(a) RESIDENCE NO. Sinai Hospital ST., 3442 Virginia Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Gurevitz

6 DATE OF BIRTH (month, day, and year): [redacted]

7 AGE: Years 47 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: L. Lewis

(Address): 1439 E Balto St

15 Filed NOV 27 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27 19 29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 19 29, to Nov. 27, 19 29, that I last saw h[illegible] alive on Nov. 27, 19 29, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis -
Primary in the stomach
Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Samuel S. Hamburger, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Hebrew Mt. Carmel — DATE OF BURIAL: 11-27, 19 29

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

TION is very important. See instructions on back of certificates.

V 27 1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51389

CERTIFICATE OF DEATH

90 E 51389

1-PLACE OF DEATH Aged Womens Home REGISTERED NO.

City of BALTIMORE: (No. 1464 W Lexington St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Ruth

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 1845

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	84	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs M E Baker

(Address) 1404 W Lexington

15 Filed ..., 19 ... Registrar

N 2 71929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Nov. 27, 1929

that I last saw h N alive on Nov. 26, 1929

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY Myocarditis

(Secandary)

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin E Jarrett M. D.

, 19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Rock Run Harford Co	Nov 29 1929
20 UNDERTAKER George J Smith	ADDRESS Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51390

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 E 51390

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ERNEST WIEPRECHT

(a) RESIDENCE NO. 2314 E. Fayette ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 7, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Wieprecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Kozlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elizabeth Wieprecht
(Address) 2314 E. Fayette St

15 NOV 27 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1929, to Nov. 27, 1929, that I last saw him alive on Nov 26 1929 and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Influenzal)

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 2314 E. Fayette St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical findings + spinal puncture

(Signed) Addison Craft Irby, M. D.

11-27 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Nov 28 1929
20 UNDERTAKER	ADDRESS
F W Bazenski	1930 Eastern

Spec.—2-29-28—L. F. S.—500 Bks.

(White)

E 51391

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51391

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 26-39 90

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Bart

(a) RESIDENCE NO. Unknown ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	74 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 067

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Henry Bart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rosetta Greenwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

Filed 2 7 1929, 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1928, to Nov. 25, 1929, that I last saw him alive on Nov. 25, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Fatal

over

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C.

(Signed) Warren W. McLean, M. D.

11-27 1929 (Address) Balto. City Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co. Greenwood Cemetery

DATE OF BURIAL Nov. 29 1929

20 UNDERTAKER C. M. Watty

ADDRESS Winfield Md.

Spec.—2-29-28—L. F. S.—500 Bks.

(Spitze)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51392

CERTIFICATE OF DEATH

135 E 51392

1.—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp ST. 22-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry C Spitze
German Aged Home

(a) RESIDENCE NO. 1938 W. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosine Spitze

6 DATE OF BIRTH (month, day, and year) March 13, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johames Spitze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records German Aged Home
(Address) Baltimore & Payson Sts.

15 Filed 2 7 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929, to Nov 26, 1929 that I last saw him alive on Nov 26, 1929 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of Nov 13 1929

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) Luther E Linde, M. D.

11/26 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 29 1929

20 UNDERTAKER [illegible]

ADDRESS 1956 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51393

CERTIFICATE OF DEATH

X 188-203 E 51393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mud Hosp St. 4-30 Ward)

2-FULL NAME Edgar V. Smith

(a) RESIDENCE NO. Reisterstown Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 1st - 1911

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	18	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Alice P. Dell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Wm H. Smith
(Address) Reisterstown Md

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows*: Fract Skull (Disposal - Fract) Auto in which he was riding collided with parked auto &c

(duration) Hr. mos. ds.

CONTRIBUTORY (Secondary) Central Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Reisterstown Rd mr Mt Gilboa

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. J. Frame M. D.

11/27 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Md	Nov 29 1929
20 UNDERTAKER	ADDRESS
Edw. C. Tipton	Hampstead Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51394

CERTIFICATE OF DEATH

E 51394

REGISTERED NO. 199

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hospital St. 42-30 Ward)

2-FULL NAME John Brown

(a) RESIDENCE NO. 550 Lee St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Brown

6 DATE OF BIRTH (month, day, and year) 28 June 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer) Iron Indust
(c) Name of employer Lowney Bros

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ala Co Md

12 MAIDEN NAME OF MOTHER Henrietta Lauden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ala Co

14 Informant Sarah Brown
(Address) 550 Lee Street

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar
11-7 1929 By ADH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fract Skull
Struck & Knocked down at intersection by hit & run driver
1 hr.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Scott St at 1100 block

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. J. Braun M. D.

11/26, 1929 (Address) 2939 W. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemtry — DATE OF BURIAL 11/29 1929

20 UNDERTAKER Walter B. Spriggs — ADDRESS 529 W. Hamburg St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51395

CERTIFICATE OF DEATH.

197 E 51395

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2015 Whittier Ave. St.) (12-59 Ward)

2-FULL NAME Charles Albert Rhode

(a) RESIDENCE NO. 2015 Whittier Ave. Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Rhode

6 DATE OF BIRTH (month, day, and year) June 8, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer John G. Rhode

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER John G. Rhode

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Leighton

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs. Howard Rhode

(Address) 2015 Whittier Ave.

15 Filed 12-7 1929 By C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Homicide)
Hemorrhage due to pistol wound of lung.
(duration) yrs. mos. 8 hrs.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) T. B. Lank (Coroner) M. D.

Nov 26 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Lorraine Cemetery	Nov. 28 1929
20 UNDERTAKER	**ADDRESS**
Wm. J. Tickner & Son	N. Pa Ave

OF DEATH in plain terms, so that it may be properly classified. Every statement of fact is very important. See instructions on back of certificate.

2 7 1929

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 51396

CERTIFICATE OF DEATH.

57 E 51396

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Light St. 24-33 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. Costello

(a) RESIDENCE. NO. 1011 Light ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer Opie's Bakery

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Margaret Hanen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mrs. J. F. Ettel (Address) 1011 Light St.

15 Filed Nov 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Nov 25, 1929, that I last saw h[illegible] alive on Nov 25, 1929, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. H. Campbell M. D.

Nov 29 1929 (Address) 664 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	11/28/29

20 UNDERTAKER E. J. Fanning & Son - ADDRESS 1938 E. Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51397

CERTIFICATE OF DEATH

91-02 E 51397

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 50 E Heath ST. 23-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James C Buckler

(a) RESIDENCE NO. 50 E Heath ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 19 1863

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer): Dawson Chemical

(c) Name of employer: Co Curtis Bay

9 BIRTHPLACE (city or town) (State or country): St Mary Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Rosa A. Lewis

(Address) 50 E. Heath St

15 Filed 2 7 1929 C19 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 29, to Nov 26, 19 29

that I last saw h[illegible] alive on Nov 26 19 29

and that death occurred, on the date stated above, at 4 43 p. m.

The CAUSE OF DEATH* was as follows:

Gangrene of Leg
& Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. H. Campbell, M. D.

Nov 27, 19 29 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Nov 29 1929

20 UNDERTAKER: J. John F. Denny — ADDRESS: 715 Light St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 129 E 51398

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Franklin ST. 4-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Charles Fulton Henry

(a) RESIDENCE NO. Jones Creek (Edgemere Point) ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 4 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily E Henry

6 DATE OF BIRTH (month, day, and year) Dec 26 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manheim Pa

PARENTS

10 NAME OF FATHER Charles F Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mt Joy Pa

12 MAIDEN NAME OF MOTHER Emma Brogatadt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fleetwood Pa

14 Informant Mrs Emily E Henry
(Address) Jones Creek

15 Filed 2 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov 26, 1929, that I last saw him alive on Nov 26, 1929, and that death occurred, on the date stated above, at 11:25 P m.

The CAUSE OF DEATH* was as fotlows:

Chronic parenchymatous nephritis with uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) M B Schreiber, M. D.

11/26, 19 29 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manheim Pa	Nov 29 1929
20 UNDERTAKER	ADDRESS
John F Denny	715 E Lombard St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 51399

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 51399

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1009 N. 40th St. 13-52 (WARD)

2-FULL NAME. Louis Atkinson

(a) RESIDENCE NO. 1009 N. 40th St. (Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ida M. Atkinson

6 DATE OF BIRTH (month, day, and year) Feb 23 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49.	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Employer.

9 BIRTHPLACE (city or town) (State or country) Balto city md.

PARENTS

10 NAME OF FATHER Allan Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ida M. Atkinson (Address) 1009 N. 40th St

15 FILED 1929 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1929, to 11/27, 1929, that I last saw him alive on 11/26, 1929, and that death occurred, on the date stated above, at 3-0-7. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Thyroid symptoms

(Signed) C. T. Culotta M. D.

11/27, 1929 (Address) 3201 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Markham Cemetery Md. DATE OF BURIAL: 11 29. 1929

20 UNDERTAKER: L. Fuller Davis ADDRESS: 3307 Pinkney St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 51400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST. WARD)

2-FULL NAME Mrs. Isadore Lieberman

(a) RESIDENCE NO. 702 S. Broadway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Lieberman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E Balto. St.

15 Filed NOV 28 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1929, to Nov. 28, 1929, that I last saw h alive on Nov. 28, 1929 and that death occurred, on the date stated above, at 3.35 A M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. P. Hessi, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Sinai Memorial Park — DATE OF BURIAL 11-28-1929

20 UNDERTAKER Jack Lewis, 1439 E Balto. St. — ADDRESS

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51401

CERTIFICATE OF DEATH

129 E 51401

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lichtenstadt

(a) RESIDENCE NO. 656 W Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jobber

(b) General nature of industry, business, or establishment in which employed (or employer) Drugs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Lewis
(Address) 1439 Eutaw St

15 Filed 12 8 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-29

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1929, to 11-27, 1929, that I last saw him alive on 11-27, 1929 and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko., M. D.

11/27, 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew — DATE OF BURIAL 11-29-1929

20 UNDERTAKER Jack Lewis, 1439 Eutaw St. — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

Potter

E 51402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 51402

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3610 Frederick Ave, St. 90-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elmer V. Potter

(a) Residence No. 3610 Frederick Ave St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	W	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Potter

6-DATE OF BIRTH (month, day and year) Oct 18 66

7-AGE. 63 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or 8 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Manager

(b) General nature of industry, business, or establishment in which employed (or employer). Hardwood & Stone

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Emanuel Potter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Hiser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Mrs Pearl Potter

(Address) 3610 Fredericke

15- Filed 2 8 1929 C. HAMPSON JONES, M. D. Registrar. By K.M.

Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) November 26/29

17- I HEREBY CERTIFY, That I attended deceased from August 26. 1929 to November 26 1929 that I last saw h alive on November 26. 1929 and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Bramwell Lango M. D.

, 19 (Address) 2937 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Nov 29, 1929
20-UNDERTAKER.	ADDRESS
W M Preston	2235 N Charles

Spec.—2-29-28—L. F. S.—500 Bks.

E 51403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 51403

1—PLACE OF DEATH

REGISTERED NO. 26-35

CITY OF BALTIMORE: (No. 3713 Trappe Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MARY MIKOLON

(a) RESIDENCE NO. 3713 Trappe Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Mikolon

6 DATE OF BIRTH (month, day, and year) October 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russian Poland

PARENTS

10 NAME OF FATHER Jacob Brodowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Jacob Mikolon (Son)

(Address) 3713 Trappe Road.

15 Filed [illegible] 19 [illegible] Registrar

2 81929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 24th 1929, to November 25th 1929, that I last saw her alive on November 26th 1929 and that death occurred, on the date stated above, at 1.40 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of descending colon

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no Family history

What test confirmed diagnosis? Physical Examination

(Signed) Arm[illegible] Resident, M. D.

11/27, 1929 (Address) Brundale, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov. 28. 1929

20 UNDERTAKER: Henry Sander & Sons. Inc. — ADDRESS: Baltimore St & Broadway.

Cor.—10-10-29—A Co.—100 Bks.

E 51404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ E 51404

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH City of Baltimore: (No. 2221 Fleet St., probably at (Declared at Hopkins 1-3 Ward)

2-FULL NAME WILLIAM ZIMMERMAN

(a) RESIDENCE NO. 2221 Fleet St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Zimmerman

6 DATE OF BIRTH (month, day, and year) February 9, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman 062
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1 year
(c) Name of employer General Electric Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dietrich Zimmerman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Meyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Louise Zimmerman (Wife
(Address) 2221 Fleet St

15 Filed NOV 28 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26, 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy (2nd stroke)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? J. H. Mc

(Signed) , M. D.

11/27/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Nov. 28, 1929

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS BALTIMORE ST & BROADWAY.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51405

CERTIFICATE OF DEATH

1948 E 51405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 12-51 Ward)

2-FULL NAME Barrington Hill

(a) RESIDENCE NO. 2815 Remington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8-1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Hill

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Susie Sprogins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mr. Wm. Hill (Father)
(Address) 2815 Remington Ave.

Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab wound of heart
Homicide.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 800 Block China St

Did an operation precede death? Yes Date of 11/23/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

11/27. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	11 28 19 29
20 UNDERTAKER	ADDRESS
Frank T. Hensley	570 Druid Hill Ave

V 28 1929 RPK

Spec.—2-29-28—L. P. S.—500 Blks.

E 51406

281425

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51406

113

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Beckman

(a) RESIDENCE NO. 247 S - Madeira ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/2/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Ray Beckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) La -

12 MAIDEN NAME OF MOTHER Irene Wrozinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Friends -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 28 1929 H. [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Nov. 27, 1929, that I last saw him alive on Nov. 27, 1929, and that death occurred, on the date stated above, at 1 55 P m.

The CAUSE OF DEATH* was as follows:

Chronic gastro enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bilateral otitis media

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. O. Y. Warner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Nov.	29 1929
20 UNDERTAKER	ADDRESS
John M Weber & Son	Chester, Pa

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51407

CERTIFICATE OF DEATH.

188-193 E 51407

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. St. 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Simon

(a) RESIDENCE NO. 513 Radnor Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Simon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Josephine Baginski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Josephine Simon

(Address) 513 Radnor Ave.

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Struck & Knocked down by moving auto.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) J. J. Traver M. D.
(Coroner)

11/28 1929 (Address) 2139 W. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Old York Road & Radnor Ave

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Date of Burial Nov. 30 1929

20 UNDERTAKER John M. Weber ADDRESS 4 W. 4th St. Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 51408

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 51408

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1455 Richardson St. (or Ward) 24-35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret L. Morris.

(a) RESIDENCE NO. 1455 Richardson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 11 mos. 11 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer A. Morris.

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1901.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	27.	11,	11,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Johns.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Schnell.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Elmer A. Morris.

(Address) 1455 Richardson St.

15 Filed 19

C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26th 19 29.

17 I HEREBY CERTIFY, That I attended deceased from November 17 19 29. to Nov. 26 19 29.

that I last saw h[illegible] alive on Nov 26 19 29.

and that death occurred, on the date stated above, at 5 25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. La Jerome, M. D.

11/27 19 29 (Address) 2818 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial Nov 29 1929

20 UNDERTAKER A. Howard Evans ADDRESS 388 Fabert

DEC 2 1929

Reg.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 51409

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 S. Carlins ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Silver

(a) RESIDENCE NO. 315 S. Carlins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth 22 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Silver

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Baltimore St.

15 Filed ..... 19.. H. A. JONES, M. D. Registrar

V 28162

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28. 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 16th, 1927, to Nov. 27, 1929 that I last saw h[illegible] alive on Nov. 27, 1929 and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Insufficiency hypertension

Uremic Toxemia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D.D. McClellan, M. D.

Nov 28 1929 (Address) 2230 Eaton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 11-28 19 29

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51410

CERTIFICATE OF DEATH

128

E 51410

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2234 Eagle St. ST. 10-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara May Ford.

(a) RESIDENCE NO. 2234 Eagle St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): May 19, 1918

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Raymond D. Ford.

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Edith Bosson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Raymond D. Ford.
(Address) 2234 Eagle St

15 Filed 2 9 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24/1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Nov 26, 1929, that I last saw h[illegible] alive on Nov 25, 1929 and that death occurred, on the date stated above, at 5-15 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis Acute

Acute Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Nov 29, 1929 (Address) 2602 Druid Park Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
London Park.	Nov 29 1929

20 UNDERTAKER: Edmondson

ADDRESS: 3115 Eastern

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 51411 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 111-001 E 51411

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. West Bolt. Gail Hosp. ST., 58 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Emory Smith

(a) RESIDENCE No. 2259 Park Ave. ST.; WARD
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geneva Smith

6 DATE OF BIRTH (month, day, and year) Dec 8 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min
52	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Pa. R.R. 013
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geneva Smith
(Address) 2259 Park Ave

15 Filed NOV 29 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 26, 1929, that I last saw him alive on Nov 26, 1929, and that death occurred, on the date stated above, at 6.05 P.M.

The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia - Post Operative

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 ds. Ruptured Gastric Ulcer
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At Home
Did an operation precede death? Yes Date of Nov 21st 1929
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Operative

(Signed) J Mactagna, M. D.
, 19 (Address) W. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL Nov 29 1929

20 UNDERTAKER Chenowith Son

ADDRESS 3615 Gwynns

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51412

CERTIFICATE OF DEATH

45 E 51412

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Simons Sinkler

(a) RESIDENCE NO. 5 Sadler St Charlestown S C WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth

6 DATE OF BIRTH (month, day, and year) Jan 7, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER William Sinkler

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Simons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed 2 9 1929, 19 HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 19 9, to Nov 28, 1929, that I last saw h.m alive on Nov 28, 1929 and that death occurred, on the date stated above, at 5 39 P m.

The CAUSE OF DEATH* was as follows:

Papilloma of Duodenum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? South Carolina

Did an operation precede death? Yes Date of Nov 25, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Report

(Signed) H. C Thompson, M. D.

11/28, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston S. Ca	11/28 1929

20 UNDERTAKER Wm Cook 12 1/2 St Paul. ADDRESS

Important. See instructions on back of certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51413

CERTIFICATE OF DEATH

170 VE 51413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 870 Washington Boulevard St., 24 Ward)

2-FULL NAME Irving Arnold

(a) RESIDENCE NO. 870 Washington Boulevard Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	36	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Trader
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Arnold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Schultz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Ella Arnold
(Address) 870 Washington Blvd

15 Filed ... 19 ... C. HAMPSON JONES, M. D.
Registrar

V 2 9 1929 D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide
Pistol Shot through head
at Home

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas J Brooks, M. D.
Nov 27. 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 11/30 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Geisy 910 W Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51414

CERTIFICATE OF DEATH

74-001 E 51414

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 873 W Fayette ST. 18-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Gray

(a) RESIDENCE NO. 873 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Gray

6 DATE OF BIRTH (month, day, and year) Apr 19 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Betty L. Eckenrode

(Address) 107 Reisterstown Rd

15 Filed 2 9 1929, 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26. 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/25/29, 19, to 11/26/29, 19, that I last saw h alive on 11/25/29, 19, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) immediate yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Leonard J. Geisy, M. D.

11/28/29 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury, Reisterstown, Md

DATE OF BURIAL 11/29 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 W Pratt St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51415

CERTIFICATE OF DEATH

188-103 E 51415

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Jos Hosp. St., 27-63 Ward)

2-FULL NAME Alton A. Huff

(a) RESIDENCE NO. 3104 Orlando St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 18 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chief
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Alton A Huff

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Ruth Lane

13 BIRTHPLACE OF MOTHER (city or town) Lawrenceburg Ky
(State or country)

14 Informant Alton A. Huff
(Address) 3104 Orlando Ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

OV 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Struck & run down by auto
Fract Femur Lt

ac (duration) 1 hr mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock
Hemorrhage Cerebral (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Front of 3104 Orlando Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. J. Braun, M. D.

11/28 1929 (Address) 2939 W Lt Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	11/29 1929
20 UNDERTAKER B. Wm Cook	ADDRESS 1212 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

51416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 E 51416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4106 Grune Court St.) 25-27 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guy Robert Riston

(a) RESIDENCE NO. 4106 Grune Court ST. Curtis Bay WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: W. White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28 24

7 AGE — Years: 3 | Months: 1 | Days: 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frank Riston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Violet Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Frank Riston
(Address) 4106 Grune Court

15 Filed NOV 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1927, to Nov 27, 1927, that I last saw h[illegible] alive on Nov 27, 1927 and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Grippe

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

11/27, 1927 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 11/29 1929

20 UNDERTAKER: Stillman Cook

ADDRESS: St. Paul & Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-25—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51417 ✓ E 51417

E 51417

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH 536 N. Lee Street

REGISTERED NO.

CITY OF BALTIMORE (No.) 536 N. Lee St. 22-30 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Edward Coberth

(a) RESIDENCE NO. 536 N. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write this word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug. 16 1889

7 AGE: Years 40 | Months 3 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): — 040

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md

PARENTS

10 NAME OF FATHER: Reuen Coberth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Laura F. Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Md

14 Informant: Laura Coberth

(Address): 536 N. Lee St.

15 Filed 9 1029 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov 26, 1929, that I last saw h[illegible] alive on Nov 26 1929 and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

1 (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) H. Wm Hopkins, M. D.

, 19 (Address) 501 N Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL: Nov 29 1929

20 UNDERTAKER: John W Toadvine and Bro — ADDRESS 1027

Spec.—1-10-21—M&T—1500 Bks.

E 51418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57 E 51418

1-PLACE OF DEATH U.S.Marine Hospital, Baltimore

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 12-51 WARD)

2-FULL NAME Edward Doddridge

(a) RESIDENCE NO. Louisville, Ky ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug.11.1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work seaman

(b) General nature of industry, business, or establishment in which employed (or employer) seaman

(c) Name of employer

0 & b.

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Fred C. Doddridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Maud Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant olinical records, (Address) Marine Hospital

15 Filed NOV 29 1929 C. HAMPSON JONES, M. D. Registrar

Per Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1928 to Nov. 28 1929

that I last saw him alive on Nov. 28 1929

and that death occurred, on the date stated above, at 9:35 a.m.

The CAUSE OF DEATH* was as follows:

diabetes mellitus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) erysipelas

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical and laboratory

(Signed) Ralph E Porter, M. D.

, 19 (Address) Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys, Hampden — DATE OF BURIAL Nov 29, 1929

20 UNDERTAKER E. Leray Stiffler, Inc. — ADDRESS 1251 N. North ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51419

CERTIFICATE OF DEATH

90 E 51419

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 925 Parrish St., 16 Ward)

2-FULL NAME Maggie Fields

(a) RESIDENCE NO. 926 Parrish St. Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 0/0
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Don't Know

14 Informant Helen Brown
(Address) 648 George St.

15 Filed NOV 29 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) H. L. Lobeck, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 11-29 1929

20 UNDERTAKER Reuel Easton — ADDRESS 916 Cathedral

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A.C.—100 Bks.

E 51420

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 51420

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 613 Brune St. 16-6 Ward)

2-FULL NAME Alfred Peety or Petty

(a) RESIDENCE NO. 613 Brune St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	83			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Anne Dorsey
(Address) 613 Brune

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

NOV 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Smith, M. D.
(Title) Coroner

Nov 26 1929

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem	11-28-29
20 (UNDERTAKER) Lord Eareckson	ADDRESS Pa 96

FOR INFORMATION ONLY. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51421

CERTIFICATE OF DEATH

65-002 ✓ E 51421

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3109 Woodland Ave- ST. 15-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris T. Meagher

(a) RESIDENCE NO. 3109 Woodland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie S. Meagher

6 DATE OF BIRTH (month, day, and year) Mar. 29, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	30 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Union Trust Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John A. Meagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary C. Schott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mamie S. Meagher (wife)

(Address) 3109 Woodland Ave.

15 Filed 19 [illegible] Registrar

NOV 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to Nov 28, 1929

that I last saw him alive on Nov 28, 1929

and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Mal. Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bubert, M. D.

(Address) 4754 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 30 1929

20 UNDERTAKER John F Denny

ADDRESS 715 Leg

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-002 E 51422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospt. Ward 16-21)

2-FULL NAME Edward E Ramsey.

(a) RESIDENCE NO. 1417 W Lexington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Mary Ramsey

6 DATE OF BIRTH (month, day, and year) March 10 - 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 062

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore.

14 Informant Mrs Frank Brown
(Address) 1417 W Lexington St.

15 Filed NOV 29 1929 19 C. HAMILTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull & Ribs
Both Sides - Struck by
Street Car in front of
1427 W. Lafayette
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. J. Brooks M. D.

Nov 27. 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Nov 30, 1929
20 UNDERTAKER John J Cowan & Son	ADDRESS 901 Hollins

IDM Should be carefully supplied. Any Should be stated EXACTLY. Any OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 51423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 51423

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Eutaw & Lafayette ST. WARD

2-FULL NAME Ethel Parker Hayes

(a) RESIDENCE NO. 1430 Presstman ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years 33 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Albert Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Priscilla Alton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Jerod Parker

(Address): 1430 Presstman St.

15 Filed NOV 29 1929 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-25 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-21-29, 19 to 11-25-29, 19, that I last saw h[illegible] alive on 11-25-29, 19, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A M Kinney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL Nov 29 1929

20 UNDERTAKER: Turgeon & Brooks ADDRESS 1436 N. Carey

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51424

CERTIFICATE OF DEATH

E 51424

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Md. Gen Hosp St., 15-17 (Ward)

2-FULL NAME Mary E. Kinnemon

(a) RESIDENCE NO. 1714 Ellamont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo S.

6 DATE OF BIRTH (month, day, and year) Mar 4 1852

7 AGE Years 77 Months 8 Days 23 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Robt D. Eldridge

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Emeline Darby

13 BIRTHPLACE OF MOTHER (city or town) N. J.
(State or country)

14 Informant Kate Eldridge
(Address) 1714 Ellamont St

15 Filed Nov 29 1929 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident Fell down steps.
Fractured Nose, Collar Bone Fractured
Shock.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. Leith, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov. 30, 1929

20 UNDERTAKER John C. Mitchell & Sons, — ADDRESS 1900 Eutaw Place

Mitch.

Use pencil or pen and ink. Write plainly. Do not use abbreviations. If any item is unknown, state "unknown." If the exact date of birth is unknown, the age should be stated. EACH ITEM should be answered with particular care, as the value of the CERTIFICATE OF DEATH is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

135 ✓

E 51425

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital 15-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Jackson

(a) RESIDENCE NO. 1349-N-Eutaw ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Jackson

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Liberty Md

PARENTS

10 NAME OF FATHER Lewis Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Kate Jackson

(Address) 1349 N Eutaw

15 Filed ... 19... Registrar

11 26 1929 [illegible] hours P M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-29

17 I HEREBY CERTIFY, That I attended deceased from 10-23-, 1929, to 11-26-, 1929, that I last saw h~~e~~alive on 11-26-, 1929 and that death occurred, on the date stated above, at 3:10 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate
Urinary Retention
Uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-19-29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H. L. Jackson, M. D.

11-19, 1929 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Liberty town, Md.	11-29, 1929
20 UNDERTAKER	ADDRESS
Samuel L Beasley	Cirele

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51426

CERTIFICATE OF DEATH.

111-001 E 51426

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) West Dale Ave & Hayward ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Harriett L. Evans

(a) RESIDENCE No. 2941 Westwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hallam M. Evans

6 DATE OF BIRTH (month, day, and year) August 23, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	41	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pennsylvania

PARENTS

10 NAME OF FATHER Thomas Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rev. Hallam M. Evans

(Address) 26 N. Morley Avenue

15 Filed 11/29 19 29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-1929

17 I HEREBY CERTIFY, That I attended deceased from 11-22 1929 to 11-29 1929

that I last saw her alive on 11-29 1929

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) Ruptured Gastric Ulcer (duration) yrs. 6 mos 6 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov 22 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones M. D.

(Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester, Pennsylvania — DATE OF BURIAL Nov. 30 1929

20 UNDERTAKER Dept Undertaking Co — ADDRESS 1003 West Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51427

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51427

44

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1027 N. Broadway ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelson C. Hofter

(a) RESIDENCE NO. 1027 N Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 2 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda L. McCanahan

6 DATE OF BIRTH (month, day, and year) 9/22/63

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas S. Hofter

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Mrs Matilda L Hofter

(Address) 1027 N Broadway

15 Filed 2 9 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 19 24, to Mar 26, 19 29, that I last saw him alive on Mar 25, 19 29 and that death occurred, on the date stated above, at 6 Mar 3 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

Hemorrhage

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Feb. 27/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/29, 19 (Address) 1100 E Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 3/29/29

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 51428

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Apts. C-L. ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sylvan R. Hecht

(a) RESIDENCE NO. Alhambra Apts. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret S. Hecht

6 DATE OF BIRTH (month, day, and year) Sept. 5th. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ret'd

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Hecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Rosewald

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland.

14 Informant Mrs. Margaret Hecht

(Address) Alhambra Apts.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

NOV 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27th. 1929.

17

I HEREBY CERTIFY, That I attended deceased from May, 1927, to Nov. 27, 1929, that I last saw h... alive on Nov. 27, 1929 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. bronchitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor L. Levy, M. D.

Nov. 27 1929 (Address) 2324 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 11/29/ 1929

20 UNDERTAKER David Sandheim

ADDRESS 115-20 W. Mt. Royal Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51429

CERTIFICATE OF DEATH

66 ✓ E 51429

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 40 S. Howard St. 4-76 Ward)

2-FULL NAME Helen Alabrurda (Senkus)

(a) RESIDENCE NO. 731 W. Lafayette St., ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? 13 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Vincent Alabrurda

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Kuklerus

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Lithuania

14 Informant Andrew Kuklerus
(Address) 731 W. Lafayette St

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zeller, M. D.

11/29. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independent	Nov 29, 1929
20 UNDERTAKER	**ADDRESS**
John Grebliunas	423 S. Paca St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51430

CERTIFICATE OF DEATH

75-001 E 51430

REGISTERED NO. 12-30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St.) (Ward)

2-FULL NAME Jonas Damuskaitis

(a) RESIDENCE NO. 210 W. Camden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 64; Months; Days; IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) Lithuania

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Unknown

14 Informant: Mary Damuskaitis
(Address) 210 W Camden St

15 Filed ..., 19... HERBERT JONES
Registrar

NOV 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Hem. Phrenia (Left Sid)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brosle, M. D.

Nov 28. 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov. 30 1929

20 UNDERTAKER: John Grabliunckas — ADDRESS: 423 S. Paca St

Spec.—8-16-29—L. F. S.—100 Bks.

E 51431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 51431

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Brooks Lane St. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Katz

(a) RESIDENCE NO. 803 Brooks Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Katz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morton Munik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E Balto. St.

15 Filed NOV 29 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29-1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 19 26, to Nov 29, 19 29, that I last saw h 4 alive on Nov 29th, 19 29 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Arterio Sclerosis - Senility

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 8 hrs da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael J Obrams, M. D.

Nov 29, 1929 (Address) 360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Sinai Park

DATE OF BURIAL 11-29-1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51432

CERTIFICATE OF DEATH

74-001
E 51432

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 914 N. Gilmor St. 16-22 Ward)

2-FULL NAME Elvin Green

(a) RESIDENCE No. 1022 N. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula

6 DATE OF BIRTH (month, day, and year) July 2 - 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	58	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Canada
(State or country)

PARENTS

10 NAME OF FATHER Frank Green

11 BIRTHPLACE OF FATHER (City) Canada
(State or country)

12 MAIDEN NAME OF MOTHER Mulvena

13 BIRTHPLACE OF MOTHER (City) Canada
(State or country)

14 Informant Lula Green
(Address) 2013 Ethel St

15 Filed NOV 29 1929, 19 HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. Leslie Haskell, M. D.
Nov 27 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 29 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Pulaski St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

51433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51433

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 16-22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Forrester

(a) RESIDENCE NO. 1157 N. Stricker ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Maud

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Forrester

6 DATE OF BIRTH (month, day, and year) Sept 16 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clara Forrester
(Address) 1157 Stricker st

15 Filed ..., 19... H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/29

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 19 29, to 11/26, 19 29, that I last saw h.. alive on 11/26, 19 29, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

11/27, 19 29 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 29 19 29
20 UNDERTAKER	ADDRESS
Thomas E. Pelson	1303 Pine

IF DEATH is plainly written, so that it may be properly important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51434

CERTIFICATE OF DEATH

45

E 51434

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4220 Belman ave ST. Overlea WARD)

2—FULL NAME Margaret C. McKewen

(a) RESIDENCE NO. 4220 Belman av ST. Overlea WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. McKewen

6 DATE OF BIRTH (month, day, and year) April 16, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Thos. Neary.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz. McGregor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. John McKewen

(Address) 4220 Belman ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27, 29

17

I HEREBY CERTIFY, That I attended deceased from Nov, 19 28, to Nov 27, 19 29,

that I last saw h.. alive on Nov 10, 19 29

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Chas F. Blake, M. D.

Nov. 19 29 (Address) 20 E Preston

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov [illegible] 19 29

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51435

CERTIFICATE OF DEATH

90 E 51435

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2504 Roslyn av ST., 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Ind. Collins

(a) RESIDENCE NO. 2504 Roslyn ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Collins

6 DATE OF BIRTH (month, day, and year) May 10-1852

7 AGE Years 77 Months 6 Days 16 If LESS than 1 day, hrs. or min. 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Accountant

(c) Name of employer Truman B & L Assn

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Evaline Grier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Edward Collins

(Address) 2504 Roslyn av

15 Filed NOV 29 1929 19 CLAMPETT JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased (from Oct. 28, 19 29 to Nov. 26, 19 29 that I last saw h alive on Nov. 25, 19 29 and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation.

Cardiac Hypertrophy and Pulmonary Tuberculosis

(duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gunical Course

(Signed) Geo. L. Wallace M.D.

19 (Address) 1114 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov. 29, 1929

UNDERTAKER John A. Truman

ADDRESS 3100 E. Balto St.

Observe the plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51436

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 V

E 51436

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Shaday

(a) RESIDENCE NO. 643 S Linwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 873 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Poland

PARENTS

10 NAME OF FATHER Andrew Shaddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Poland

12 MAIDEN NAME OF MOTHER Annie Paleu

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Poland

14 Informant Records

Address BALTIMORE CITY HOSPITALS

NOV 29 1929

15 Filed ... 19 ... CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-29

17 I HEREBY CERTIFY, That I attended deceased from 10-16, 1929, to 11-27, 1929, that I last saw h[illegible] alive on 11-27, 1929 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) over 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Syphilis Aorta & Insufficiency

(duration) over 2 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E. Lab. W.R. Autopsy

(Signed) Wharton M. McLean, M. D.

11-28, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart.

DATE OF BURIAL Nov. 29, 1929

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 51437

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. 16 68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eva Hamilton

(a) RESIDENCE No. Denton Ave Fort Howard ST, WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander Hamilton

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: About 49 (Years / Months / Days / If LESS than 1 day, hrs or min)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Alexander Howard Ft Howard Md

15 Filed NOV 29 1929 19 H. L. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 19 29.

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 19 29, to Nov 28, 19 29, that I last saw h 9 alive on Nov 28, 19 29 and that death occurred, on the date stated above, at 2 a m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J K Rossi M. D.

, 19 (Address) Wardour & Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ~~Ft Howard~~ Dist Clerk Natl Cemetery DATE OF BURIAL 11/30 29

UNDERTAKER: H. H. Cook ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51438

CERTIFICATE OF DEATH.

111-002

E 51438

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. 9-46 ST. WARD)

2-FULL NAME Alfred Boulden

(a) RESIDENCE NO. 1131 Homestead St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Boulden

6 DATE OF BIRTH (month, day, and year): Feb 29 1875

7 AGE: Years 54 Months 8 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocers Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Delong & Lade

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Daniel Boulden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Eliza Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Lena Boulden 1131 Homestead St

15 Filed . 19. HAMPSON JONES, U. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Nov 28, 1929, that I last saw h[illegible] alive on Nov 25, 1929, and that death occurred, on the date stated above, at 10 50 p.m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/21/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S H Barranco, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 12 2 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 E Pratt St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51439

CERTIFICATE OF DEATH.

90 E 51439

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 70 & Evesham Ave St. 27-48 Ward 6

2-FULL NAME Charles Tubman Beauchamp

(a) RESIDENCE NO. 70 & Evesham Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Deborah Beauchamp

6 DATE OF BIRTH (month, day, and year): Mar. 9th 1855

7 AGE: Years 74 Months 8 Days 18 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Capt. do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Merchants & Miners Steamship

9 BIRTHPLACE (city or town): Somerset County Md

(State or country)

PARENTS

10 NAME OF FATHER: Theodore Beauchamp

11 BIRTHPLACE OF FATHER (city or town): Somerset Co. Md

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Parks

13 BIRTHPLACE OF MOTHER (city or town): Somerset County

(State or country)

14 Informant: Mrs Deborah Beauchamp

(Address) 70 Evesham Ave

15 Filed....., 19..... C. HAMILTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D. (Coroner)

11/29/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Date of Burial 11/30 1929

20 UNDERTAKER: [illegible] ADDRESS 1217 N Paul St

W 51439

Spec.—2-29-28—L. F. S.—500 Bks.

E 51440 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 51440

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert St. ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Gladstone

(a) RESIDENCE NO. 1224 Halbrook ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Talbot

6 DATE OF BIRTH (month, day, and year) Oct 27 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Charles Gladstone

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Catherine Talbot

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Catherine Gladstone

(Address) 1224 Halbrook St

15 Filed 12 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 19 29, to Nov. 28, 19 29, that I last saw h[illegible] alive on Nov. 28, 19 29 and that death occurred, on the date stated above, at 1 10 P.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerotic Cardiovascular Disease, Cardiac Decompensation.

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sara F. Guiglia, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 12-2 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 51441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-09 E 51441

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland (Ward) 1

2-FULL NAME Baby Doris Harzarik

(a) RESIDENCE No. 3038 Boston ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 2, 1929

7 AGE — Years: + — Months: 10 mo. Days: 25 — If LESS than 1 day, .. hrs. or .. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None - old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm. Harzarik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Eva Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Wm. Harzarik

(Address) 3038 Boston St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-15, 1929, to 11-27, 1929, that I last saw h alive on 11-27, 1929, and that death occurred, on the date stated above, at 9 20 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? autopsy + physical

(Signed) ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem.

DATE OF BURIAL: Nov 30 1929

20 UNDERTAKER: H. Sander Sons Inc

ADDRESS: 1710 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 29 1929

HAMPDEN JOINTS

Cor.—12-9-25—A Co.—200 Bks.

Attaker Pulpan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51442

CERTIFICATE OF DEATH.

166

E 51442

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Druid Hill Ave. St., 9-18 Ward)

2-FULL NAME Attaker Pulpan

(a) RESIDENCE NO. 1613 Holbrook St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Sing 1855

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Son 1857

6 DATE OF BIRTH (month, day, and year): Jan 6 1857

7 AGE: Years 74 74 Months 10 Days 21

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon 040

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Keeper

(c) Name of employer: Self employed

9 BIRTHPLACE (city or town)

(State or country): Hungary

PARENTS

10 NAME OF FATHER: Attaker Pulpan

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Hungary

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Hungary

14 Informant: Mrs Lina Silbernberg

(Address) 1613 Holbrook St

15 Filed ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot Wound Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner)

11/29 1929 (Address) 3632 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Date of Burial Nov 29 1929

20 UNDERTAKER: Chas. L. Sleyster ADDRESS 415 E Fort Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51443

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 ✓ E 51443

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1737 N. Broadway ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Reiley.

(a) RESIDENCE NO. 1737 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Reiley.

6 DATE OF BIRTH (month, day, and year) Feb. 3rd 1854

7 AGE Years	Months	Days 25	If LESS than 1 day, ... hrs. or ..... min.
75	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 07

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Penna.
(State or country)

PARENTS

10 NAME OF FATHER Connelly

11 BIRTHPLACE OF FATHER (city or town) Penna.
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Penna.
(State or country)

14 Informant Thomas J. Reiley Husband
(Address) 1737 N. Broadway.

15 Filed ....., 19... C. HAMPSON JONES, M. D.
Registrar

DEC 2 6 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28th 1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 1928, to Nov 28, 1929, that I last saw h[illegible] alive on Nov ....., 1929, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(Senile Dementia)

..... (duration) 3+ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None required

(Signed) S. Lloyd Wilson, M. D.

, 19 (Address) 720 E. Fredrick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fawn Grove Penna Friends Burial Ground	Dec 2nd 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

51444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 51444

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home (If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1404 W Lexington St. 14-21 Ward)

2-FULL NAME Isabel Rosenburger

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16, 1843

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
86	85	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs M E Baker

(Address) 1404 W Lexington

15 Filed NOV 29 1929 C. HAMPSON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929 to Nov 27, 1929 that I last saw h[illegible] alive on Nov 26, 1929 and that death occurred, on the date stated above, at 11 25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix Uteri

Abdominal organ Localization Not determined, discovered by Enlarged glands (duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Oct

Was there an autopsy? No What test confirmed diagnosis? Microscopic Exam.

(Signed) Edward H Jarrell M. D.

, 19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial NOV 29 1929

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51445

CERTIFICATE OF DEATH

90

E 51445

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Edward Hall

(a) RESIDENCE NO. 1315 Lemon St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Coart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..... 19..... Registrar

NOV 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 19 29 to Nov. 26, 19 29, that I last saw him alive on Nov. 26, 19 29 and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease rontracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.E.

(Signed) Marvin W. McLean, M. D.

11-27, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL Nov. 30, 1929

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51446

CERTIFICATE OF DEATH

90 E 51446

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 825 Sarah Alley (ST., or WARD)

2—FULL NAME Jam. F Powell

(a) RESIDENCE NO. 825 Sarah Alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Della Thomas

(Address) 1634 Bolton

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Nov 27, 1929, that I last saw h..... alive on Nov 2d, 1929 and that death occurred, on the date stated above, at 11 A m. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? ..... Date of No

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) T Woodward, M. D.

Nov 29, 1929 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 29, 1929
20 UNDERTAKER	ADDRESS 322 N
Mrs. Katie R. Williams	Schroeder St

NOV 29 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51447

45 E 51447

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Moore

(a) RESIDENCE NO. 933 Shells Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1856 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Daniel Moore

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosie ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed NOV 29 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-29

17 I HEREBY CERTIFY, That I attended deceased from 11-19, 1929, to 11-28, 1929, that I last saw him alive on 11-28, 1929 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma ? of Rectum

(duration) over yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis : Hypertension

(duration) over yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: C.C.

(Signed) Harris M. McLean, M. D.

11-28, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cemetery	Dec 2, 1929
20 UNDERTAKER	ADDRESS
Mrs. Kate R Williams	3227 Edmondson Ave

IMPORTANT: Answer all questions carefully and completely. Write plainly with pen and ink. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51448

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Howard Newkirk

(a) RESIDENCE NO. 1503 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Mary E Newkirk

6 DATE OF BIRTH (month, day, and year): Nov 28 1874

7 AGE: 54 Years 53+ | Months 11 | Days 29. | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: John Newkirk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary E Newkirk

(Address) 1503 W Baltimore st

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/27/29

17 I HEREBY CERTIFY, That I attended deceased from 11/27, 19 29, to 11/27, 19 29, that I last saw him alive on 11/27, 19 29 and that death occurred, on the date stated above, at 9:15 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 12 mos. 7 ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? exam.

(Signed) Theo. E. Stacy, M. D.

, 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 11/29/29

20 UNDERTAKER: Engelke Turley

ADDRESS: Pacific & Fayette

mation should be entirely supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51449

CERTIFICATE OF DEATH.

31

E 51449

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1843W Fayette St. 19-27 Ward)

2-FULL NAME Naomi Kenny.

(a) RESIDENCE NO. 1843W Fayette St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Kenny

6 DATE OF BIRTH (month, day, and year): March 19, 1900

7 AGE: Years 29 Months 8 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Herman C Waltemeyer

11 BIRTHPLACE OF FATHER (city or town): Frederick

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lillie Snyder

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: John Kenny (Husband)

(Address): 1843 W Fayette St

15 Filed 12-9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1928, to Nov. 27th, 1929, that I last saw her alive on Nov. 27th, 1929, and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings & X Ray

(Signed) Alex A Wennstedt, M. D.

11/29/1929 (Address) 713 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem Date of Burial Dec 2nd 1929

20 UNDERTAKER: Charles F. Dill ADDRESS 10 Frederick Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

29 1929

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51450

CERTIFICATE OF DEATH.

11/29

E 51450

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 543 N Carrollton Ave ST.) 18-16 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josie Virginia Cooper

(a) RESIDENCE. No. 543 N Carrollton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-20-1874

7 AGE: Years 55; Months 0; Days 9; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia Edinburg

PARENTS

10 NAME OF FATHER Geo Jacob Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Dorcas Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mary Cooper (Sister)

(Address) 543 N Carrollton Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., Registrar

NOV 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-1929

17 I HEREBY CERTIFY, That I attended deceased from 12-27-27, 19 , to 11-29-, 1929.

that I last saw her alive on 11-28-, 1929.

and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

Chronic nephritis

Hypertension

(duration) 1 yrs. 11 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Abner Barker, M. D.

11/29, 1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edinburg Va.

DATE OF BURIAL: Dec 1 1929

20 UNDERTAKER: Wm. J. Tickner & Son

ADDRESS: Edinburg Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 51451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 51451

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 Edmondson Ave 16-17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary L Wilson

(a) Residence No. 1200 Edmondson Ave, Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? 73 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Don't Know

7-AGE. 73 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)..... do

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Matthew Wilson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Rebecca J. Morland

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Miss Eva L. Wilson

(Address) 1200 Edmondson Ave

15- (Filed) C. HAMPSON JONES, M. D. Registrar.

NOV 29 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 27/29

17- I HEREBY CERTIFY, That I attended deceased from abt 15 months 29, 19.. to Nov. 27 19.29.

that I last saw h.e.r alive on Nov. 24 19.29.

and that death occurred, on the date stated above, at 5-1201 m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Uncertain

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) William B. Ryder, M. D.

, 19 (Address) Cypress Mills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 30. 19.29.

20-UNDERTAKER, Geo W Little — ADDRESS 2700 Edmondson Ave

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should write plainly in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51452 ✓ 9 E 51452

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1427

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis DeCarlo

(a) RESIDENCE NO. 1515 W. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John DeCarlo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosie Cutinco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John DeCarlo

(Address) 1515 W. Fayette St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Nov 29, 1929, that I last saw h[e] alive on Nov 29, 1929, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Zell, M. D.

Nov 29, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 30 1929

20 UNDERTAKER Frank V. Petitone

ADDRESS 2818 E. Baltimore

V 2 9 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 51453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 146

E 51453

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Della Robey

(a) RESIDENCE NO. Alberton Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Robey

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alberton Md

PARENTS

10 NAME OF FATHER John Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Elsrode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records (Address)

15 Filed NOV 29 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-23- 1927 to 11-27 1927.

that I saw h[er] alive on 11-27 1927,

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Hemorrhage

Following Abortion about 2½ months

Cause unknown

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed J. Ivy Crampton, M. D.

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 2 1929

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

N. B. WHITE PAPER ONLY. TYPEWRITER CARBON. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88-203 ✓ E 51454

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's Hospital St., 9-17 Ward)

2-FULL NAME Emma Mead

(a) RESIDENCE NO. Ferguson Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) October 15, 1869

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
✓ 60	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamtress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

069

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Oswald Mead

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Mead

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John B. Wallering
(Address) 1604 E. Lafayette Avenue

NOV 29 1929, 19 C. HAMILTON JENKINS M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
Struck by auto while walking along road
(duration) 0 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Comp. Com. Multiple Fract. Tibia & Fibula
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harford & Texas Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame M. D.

11/29 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 11/30/29

20 UNDERTAKER George J. Ruth

ADDRESS 1735 HARFORD AVE.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 ✓ E 51455

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hosp Nas 26-39 St., Ward)

2-FULL NAME Umberto De Santis

(a) RESIDENCE NO. 112 N. Kresson Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) July 23, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
✓	3	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Giuseppe De Santis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Carmela De Matteis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Giuseppe De Santis
(Address) 112 N. Kresson Street

15 Filed NOV 29 1929 19 C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Knocked down & run over by truck.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Traumatic Shock

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? in front of 104 Kresson

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirms diagnosis? Clinical

(Signed) G. J. Frame, M. D.

11 29. 1929 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 11,30 1929

20 UNDERTAKER George J. Ruth

ADDRESS 1735 HARFORD AVE

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 51456

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hospitals ST., 4-36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Johnson

(a) RESIDENCE NO. 505 W. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy Mennemen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 2 9 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-29

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1928 to 11-22, 1929

that I last saw him alive on 11-22, 1929

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pharynx and soft Palate

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

11-23, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

NOV 2 - 1929

UNIVERSITY OF MARYLAND

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

29

E 51457

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Goetzke.

(a) RESIDENCE NO. 3315 Burleith Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elbert Goetzke

6 DATE OF BIRTH (month, day, and year): Sept. 4, 1905

7 AGE: Years 24 | Months 2 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Pittsburg Pa

PARENTS

10 NAME OF FATHER: Charles H Dasch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Harriet Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Elbert Goetzke

(Address): 3315 Burleith Ave

15

NOV 29 1929

O. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/27/29.

17

I HEREBY CERTIFY, That I attended deceased from 11/25/29, 19..., to 11/27, 19 29.

that I last saw h[illegible] alive on 11/27/29, 19...

and that death occurred, on the date stated above, at 6:50 m.

The CAUSE OF DEATH* was as follows:

Tetanus, acute.

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) Henry F. Helwit, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 11/30 1929

20 UNDERTAKER: W M Cook

ADDRESS: 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51458

CERTIFICATE OF DEATH

101-001 E 51438

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1635 N. Vincent St. 15-21 Ward)

2-FULL NAME Ruth Forest

(a) RESIDENCE NO. 1635 N. Vincent St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmle	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6 DATE OF BIRTH (month, day and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) no
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Martha Hurley
(Address) 1635 N. Vincent

Filed NOV 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 28 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry)
find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Nov 29 1929 Hobart Koontz, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-29 1929

20 UNDERTAKER David Carter & Co

ADDRESS 916

Spec.—1-12-23—M&T—500 Bks.

E 51459 HEALTH DEPARTMENT—CITY OF BALTIMORE C 51459

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2444 Druid Hill Ave ST. 13-59 WARD)

2-FULL NAME Wm Taylor

(a) RESIDENCE NO. 2444 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years 56 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer - ob

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Isaac Taylor

11 BIRTHPLACE OF FATHER (city or town) N. C. (State or country)

12 MAIDEN NAME OF MOTHER Maggie Mutter.

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Sarah Taylor - (Address) 2444 Druid Hill Ave

15 NOV 30 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-4, 1929, to 11-26, 1929, that I last saw h alive on 11-26, 1929, and that death occurred, on the date stated above, at 6 20 PM

The CAUSE OF DEATH* was as follows:

Ch. Nephritis & Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Carl Watts, M. D.

11/27 1929 (Address) 2444 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Nov 30 1929 DATE OF BURIAL

UNDERTAKER Virginia A. Brooks ADDRESS 1463 N. Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

V 30 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51460

CERTIFICATE OF DEATH

X 90

E 51460

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 151 W Saratoga St. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thos Hill

(a) RESIDENCE NO. 1507 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence B. Hall

6 DATE OF BIRTH (month, day, and year) Unknown 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co (State or country) Va

PARENTS

10 NAME OF FATHER Ned Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Dandas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Florence B. Hall

(Address) 1517 W. Saratoga

15 Filed DEC 3 0 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 29, 1929, that I last saw him alive on Nov 28, 1929 and that death occurred, on the date stated above, at 4.10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) W. M. Statler M. D.

11/29, 1929 (Address) 1515 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bowlers Mill Essex Co Va

DATE OF BURIAL Dec 1 1929

20 UNDERTAKER Sam H. Chase Inc

ADDRESS 1400 Monroe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51461

CERTIFICATE OF DEATH

1/90

E 51461

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Hopkins

(a) RESIDENCE NO. 731 Cross ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gen

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER Samuel L. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Pa.

12 MAIDEN NAME OF MOTHER Priscilla Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Pa.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 DEC 30 1929 C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-29

17 I HEREBY CERTIFY, That I attended deceased from 6-8, 19 28, to 11-26, 19 29, that I last saw h. alive on 11-26, 19 29 and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Acute

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin T. McClean, M. D.

11-27, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 11-30 1929

20 UNDERTAKER Byron & Wright 1218 McElderry St

ADDRESS

Information should be carefully supplied. AGE should be stated IN YEARS. If UNDER 1 YEAR, state in DAYS. If UNDER 1 DAY, state HOURS or MINUTES. OCCUPATION should indicate the trade, profession or particular kind of work, whether employer or employee, as well as the general nature of the industry, business or establishment in which employed. Write plainly in ink. Do not use abbreviations or ditto marks. Every question must be answered, or a reason given for the omission. Items 16 to 20 are important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51462

CERTIFICATE OF DEATH.

90 E 51462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2430 Oak St 12-51 Ward)

2-FULL NAME Willis Briggs

(a) RESIDENCE NO 2430 Oak St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett Briggs.

6 DATE OF BIRTH (month, day, and year) Unknown, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Harriett Briggs.

(Address) 2430 Oak St.

15 Filed 19

Registrar

C. HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Hostmann M. D.

(Coroner)

11/29 1929 (Address) 3202 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — Date of Burial: Nov. 30 29

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Linden Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V 30 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 51463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 51463

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Lydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Casey Dunmore

(a) RESIDENCE NO. 507 Calvin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col-	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work dish-washer

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant 10 0

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Sandy Dunmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha Atkison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Hosp. Records

(Address)

15 Filed NOV 30 1929, 19 Registrar C. HAMPSON JONES, M. D.

Reg. 448

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1929, to Nov 29, 1929, that I last saw h~~im~~ alive on Nov. 28, 1929 and that death occurred, on the date stated above, at 3 00 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 0 yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 507 Calvin St —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical findings Spinal puncture

(Signed) Addison Craft Early M. D.

11-29 1929 (Address) Lydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	30 1929
20 UNDERTAKER	ADDRESS
Mrs R H Elliott.	1725 Eastern Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Literal answers should be given to questions. Do not use abbreviations. Write plainly in ink. Do not omit any item. If unknown, say so. Do not leave blanks. Be sure that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

NOV 30 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51464

CERTIFICATE OF DEATH

172 ✓ E 51464

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 7-10 Ward)

2-FULL NAME Paul Miller

(a) RESIDENCE NO. 688 N Montford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK.—THIS IS A PERMANENT RECORD. Every item must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2-1880

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
49	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C. Hohman

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Fray Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Hahn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Hedwig Huber
(Address) Frankford Ave

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Jump from Window
Rupture of Bladder
(duration) yrs. mos. 30 M ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. C. Gladden, M. D.

(Address) 1436 Bway

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov 30 1929

20 UNDERTAKER Wm C. Miller & Son ADDRESS 2384 E Fayette

NOV 30 1929

Cor.—10-10-29—A Co.—100 Bks.

E 51465

HEALTH DEPARTMENT—CITY OF BALTIMORE

Leslie Hewitt Keyes

CERTIFICATE OF DEATH

88-01 E 51465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St. 18-N Ward)

2-FULL NAME Leslie Keys

(a) RESIDENCE NO. 872 W. Baltimore St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bertha M. (nee Lockard)

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	35	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) R.R.
(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town)
(State or country) Canada

PARENTS

10 NAME OF FATHER Andrew Keys

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Canada

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Mrs. Leslie Hewitt Keys
(Address) 872 W. Baltimore St.

15 Filed ...19...

C. HAMPSON JONES, M.D. Registrar.

NOV 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said ... find that said deceased came to ... death
(Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Accident R.R.
Fractured pelvis
Shock.

(duration) ...yrs. 2 hours

CONTRIBUTORY
(Secondary)
(duration) ...yrs. ...mos. ...

18 Where was disease contracted? If not at place of death? Sparrow Point
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular

(Signed) H. Keyes Lynch, M.D.
(Address) Coroner N-W

NOV 30 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Finksburg, Md. DATE OF BURIAL: Dec. 1, 1929

20 UNDERTAKER: Harry J. Fritzlan ADDRESS: 1531 W. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 100 E 51466

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. St. 46-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harrison Porter

(a) RESIDENCE NO. 746 S. Nicholas Ave N.Y.C. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Porter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed NOV 30 1929 C. HARRISON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-29

17 I HEREBY CERTIFY, That I attended deceased from 10-12, 1921, to 11-20-, 1929

that I last saw h[illegible] alive on 11-20-, 1929

and that death occurred, on the date stated above, at 9 49 P m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Gangrene right middle toe

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Humphreys, M. D.

11-26-1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

HNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health.

[illegible] E. MONUMENT

DATE OF BURIAL 19

ADDRESS NOV 29 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51467

CERTIFICATE OF DEATH

129 ✓ E 51467

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3920 Fait ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Kehres

(a) RESIDENCE NO. 3920 Fait ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Kehres

6 DATE OF BIRTH (month, day, and year) March 8-1850.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Rossmark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) don't know

14 Informant Eva Rossmark

(Address) 818 S. Lemmby

15 Filed NOV 30 1929, 19 E. HUMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 1929, 19, to Nov 28 1929, 19, that I last saw her alive on Nov 28 1929, 19, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) One mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & laboratory

(Signed) [illegible], M. D.

11-29, 19-29 (Address) 3400 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL Dec. 1 1929

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E Eagust

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51468

E 51468

CERTIFICATE OF DEATH.

REGISTERED NO. C 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7113 N. Pulaski St.; 15-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise C. Cook

(Residence in Baltimore: No. 7113 Pulaski St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, —— OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, June 13 (Month) (Day), 1866 (Year)

7-AGE, 63 yrs. 5 mos. 14 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 83

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Elizabeth Geisel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Harry Wartake

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Cook

(Address) 7113 N. Pulaski

15-

Filed ..... 1929 C. HAMPSON JONES, M. D.

By ..... Registrar.

NOV 30 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1929, to Nov 27 1929, that I saw her alive on Nov 27 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Kloss M. D.

....., 191... (Address) 7737 Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, Nov 30, 1929

20-UNDERTAKER, Margaret E. Flynn

ADDRESS 1422 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51469

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51469

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1524 Brentwood Ave ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Vase

(a) RESIDENCE NO. 1524 Brentwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lussie Vase

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nabby Co. Va

PARENTS

10 NAME OF FATHER Elbert Vass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sallie Vass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lussie Vass

(Address) 1524 Brentwood Ave

15 Filed NOV 30 1929 C. HARRISON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 29

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to Nov. 27, 1929, that I last saw h alive on Nov 27, 1929 and that death occurred, on the date stated above, at 6:10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Vascular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Louis C. Johns, M. D.

Nov. 29 (Address) 2329 Lemont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Land	11 30 1929
20 UNDERTAKER	ADDRESS
Jones Funeral Home	1516 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 51470

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 779 W Saratoga St (WARD) 8-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Kendricks

(a) RESIDENCE NO. 779 N. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Kendricks

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Augusta Ga

PARENTS

10 NAME OF FATHER Hendricks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Katie Kendrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Carrie Kendricks

(Address) 779 N Saratoga St.

15 Filed NOV 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov. 26, 1929, that I last saw h[illegible] alive on Nov 26, 1929 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Nauk E. Magruder M. D.

11/29, 1929 (Address) 1006 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11 30 1929
20 UNDERTAKER	ADDRESS
Chas L Hemsley	[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

NOV 30 1929

Spec.–7-17-26—A Co.—200 Bks.

E 51471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51471

REGISTERED NO.

1-PLACE OF DEATH 917 W. Carrollton Ave

City of BALTIMORE: (No. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvert Gray

(a) RESIDENCE NO. 917 Carrollton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1, 1923

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school - boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Youngie Gray

11 BIRTHPLACE OF FATHER (City or town) Calvert Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Ford

13 BIRTHPLACE OF MOTHER (city or town) Crystal City,

(State or country) N. C.

14 Informant Viola Gray

(Address) 917 W. Carrollton Ave.

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-29 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 11/29, 19, to Nov 27-29, 19,

that I last saw h[illegible] alive on 11-26-29, 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? 917 Carrollton

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W R Boyton, M. D.

19 (Address) 1512 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Union Cemetery	Nov. 30, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N Schroeder St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 30 1929

MARGIN RESERVED FOR BINDING

Spec.—8-16-29—L. F. S.—100 Bks.

E 51472

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 51472

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 East 22 St., 12-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Rannie

(a) RESIDENCE NO. 310 East 22nd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary J. Rannie

6 DATE OF BIRTH (month, day, and year) Aug 22-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Rannie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Isabella Rannie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mary J. Rannie

(Address) 310 East 22nd

15 Filed NOV 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30-29

17

I HEREBY CERTIFY, That I attended deceased from 1926, ~~15~~, to 11-30, 1929, that I last saw h[illegible] alive on 11-29, 1929 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

CHR. MYOCARDITIS

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 1129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
David Ridge	12/2 1929
20 UNDERTAKER Jas. L. Merrey Son Inc.	ADDRESS 54 Ronnie

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

NOV 30 1929

Spec.—2-29-28—L. F. S.—500 Blks.

Druncilla Jackson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51473 X 146 E 51473

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 11-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Druncilla Jackson

(a) RESIDENCE NO. 371 Preston ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	cd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Jackson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alex. Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Archer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr. Fred Ball

(Address) 2145 Ward Pl. N.W. Wash. D.C.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-29

17

I HEREBY CERTIFY, That I attended deceased from 10-16- 29, to 11-28 29

that I last saw her alive on 11-28-29, 19

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

Probable Pelvic Thrombosis

(Full term pregnancy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 10-18-29

Was there an autopsy? No Curettage of Uterus

What test confirmed diagnosis? clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Funstella Station, Va.	11/30/ 1929
20 UNDERTAKER	ADDRESS
Procure A. Brown	1631 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

230113 E 51474 46 E 51474

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Albers

(a) RESIDENCE NO. Preston Apt. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Jno Grazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger -

12 MAIDEN NAME OF MOTHER Magdalena Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger -

14 Informant Friends -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar
By RMH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Nov. 30, 1929, that I last saw her alive on Nov. 30, 1929 and that death occurred, on the date stated above, at 8 50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary inoperable with metastases to bladder & vertebrae

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at patient's home

Did an operation precede death? Yes Date of Oct. 19, 1929

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) H. S. Everett, M. D.

11-30, 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 2 1929
20 UNDERTAKER Henry Wenkens & Son	ADDRESS Cyl... Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51475

CERTIFICATE OF DEATH.

186-103 E 51475

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2023 W Lanvale St.) (Ward) 16-17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E Hurley

(a) RESIDENCE NO. 2023 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hurley

6 DATE OF BIRTH (month, day, and year) Dec 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
84	85	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Peter Stallins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Ella Bell

(Address) 2023 W. Lanvale St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28/ 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death (Accident) in the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull

Run down while crossing street (by automobile)

ac (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Clavicle & Tibula

Multiple (duration) mos. ds.

11/30 1929 (Signed) J J Brown M. D. (Coroner) (Address) 2939 W. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial 12/2nd 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EC 1

Spec.—1-12-23—M&T—500 Blks.

Dr Lewis

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51476 — 185 — E 51476

1 PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) West Balto. Gen'l Hosp. (St.) 6-W (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Harriett Adams.

(a) RESIDENCE No. 1017 N. Fulton Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Adams

6 DATE OF BIRTH (month, day, and year): March 12th 1859

7 AGE — Years: 70 — Months: 8 — Days: 17 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Conwayville Md

PARENTS

10 NAME OF FATHER: John M. Beckwith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conwayville Md

12 MAIDEN NAME OF MOTHER: Henrietta T Comer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conwayville Md

14 Informant (Address): Miss Ortude Adams 193 Woodland Rd N.J.

15 Filed DEC 1 1929 C. HAMPSON JONES, M. D. Registrar

For RMH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1929, to Nov 29, 1929

that I last saw h alive on Nov 29 1929

and that death occurred, on the date stated above, at 6.20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Left Femur (duration) yrs. 0 mos. 31 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray + Clinical

(Signed) S. D. Lewis, M. D.

, 19 (Address) Winbern Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: 12/2/29

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51477

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 East 34th St. ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Stevens,

(a) RESIDENCE NO. 607 East 34th St/ ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

6a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Katherine B. Stevens,

6 DATE OF BIRTH (month, day, and year) October 7.1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Carver

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER George Stevens,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mississippi,

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Katherine B. Stevens

(Address) 607 East 34th St.

15 Filed DEC 1 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 1929 to Nov 30 1929 that I last saw h in alive on Nov 29 1929 and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Heart Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical.

(Signed) J. Wade Thomas, M. D.

Nov 30 1929 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 19

20 UNDERTAKER Geo W Little

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. This is a permanent record. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51478

CERTIFICATE OF DEATH

5 V E 51478

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 Vickers Road ST. 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Grote,

(a) RESIDENCE NO. 3202 Vickers Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? 60 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

6a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE~~ of Sophia Grote,

6 DATE OF BIRTH (month, day, and year) March 31. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Grote,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Sophie Grote
(Address) 3202 Vickers Road

15 Filed ..., 19 ... Registrar

DEC 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from August 22. 1928. to Nov 30. 1929.

that I last saw h[illegible] alive on Nov. 30. 1929

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis
Rheumatic Toxemia

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer, M. D.

12/1, 1929 (Address) 3300 N. Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	19
20 UNDERTAKER Geo W Little	ADDRESS

DEC 2 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 51479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-203

E 51479

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hosp. St. 4-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Louis Christopher

(a) RESIDENCE NO. 651 West Lombard St. Ward 94

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Christopher

6 DATE OF BIRTH (month, day, and year) March 28th 1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	8.	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Deltaville

(State or country) Virginia

PARENTS

10 NAME OF FATHER Emmett Christopher

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Victoria Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mrs. ME. Christopher

(Address) Portsmouth Va.

15 Filed ..... 19 C. HARRY JONES, Registrar

DEC 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull

Runover by moving auto at 12-30 pm while lying in center of road

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia

(duration) yrs. mos. ds.

(Signed) J. J. Frame, M. D.

(Coroner)

12/1, 1929 (Address) 2939 no Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death None yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Washington Rd - 2 mile north of Laurel

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth, Va. Date of Burial 19

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W Baltimore St

FILE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51480

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

87 E 51480

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 238 N Monroe ST. 20-27 (WARD)

2-FULL NAME Margaret Ellen Caulk

(a) RESIDENCE NO. 238 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Chas S Caulk

6 DATE OF BIRTH (month, day, and year) Oct 14, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Cincinnati (State or country) Ohio

PARENTS

10 NAME OF FATHER Denis Scully

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cassie Mahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Anna M Lentz

(Address) 238 N Monroe St

15 Filed DEC 1 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Nov 28, 1929, that I last saw her alive on Nov 28, 1929, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) 0 yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Rheumatic arthritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. O'Neill M. D.

11/30, 1929 (Address) 108 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Dec 1, 1929

UNDERTAKER Margaret G. Flynn — ADDRESS 1417 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—19-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51481

CERTIFICATE OF DEATH

74-00 E 51481

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 815 S. Grove St., 27-36 Ward)

2-FULL NAME Priscella Maddox

(a) RESIDENCE NO. 815 S. Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Maddox

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 50 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Perry Alcorn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Fannie Baldie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Sophie Woodland
(Address) 706 Edmondson Ave

15 Filed ..... 19 ..... C. PHILIPSON JONES, M.D. Registrar

DEC 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talbot, M. D.

11/30. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 11-30-1929

20 UNDERTAKER: David Easton

ADDRESS 216 Bo.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51482

1—PLACE OF DEATH

REGISTERED NO. 28-77

CITY OF BALTIMORE: (No. 17 S. Wickham Rd ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maud M. Brooks

(a) RESIDENCE NO. 17 S. Wickham Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Noah S. Brooks

6 DATE OF BIRTH (month, day, and year): Jan 26-1867

7 AGE: Years 62 | Months 8 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fairmount West Va

PARENTS

10 NAME OF FATHER: M Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fairmount West Va

12 MAIDEN NAME OF MOTHER: Mary A. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va Fairmount West

14 Informant: Noah S Brooks

(Address): 17 S Wickham Rd

15 Filed DEC 1 1929 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30/29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1929, to Nov 30th, 1929, that I last saw h— alive on Nov 30th, 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary): Metastasis of both lungs

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1929

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) J. Chas Macgill, M. D.

Nov 30th, 1929 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount West Va

DATE OF BURIAL: 12/3 1929

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Catonsville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51483

CERTIFICATE OF DEATH

90

E 51483

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2750 Maryland St. WARD 12

2—FULL NAME Ella Munder

(a) RESIDENCE NO. 2750 Maryland St. WARD 12
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 27 ds. How long in U. S., if foreign birth 65 yrs. 0 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov-2-1864

7 AGE — Years: 65 | Months: 0 | Days: 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Theophilus Munder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Emilie Inderrieden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Mrs Eugene A Slack (sister)
(Address): 1803 Virginia Ave

15 Filed DEC 1 1929 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/29/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Nov. 25, 1929, that I last saw her alive on Nov. 25, 1929 and that death occurred, on the date stated above, at about midnight m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Stephens, M. D.

11/30, 1929 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec. 2. 1929.

20 UNDERTAKER: Stewart Mortuary Co — ADDRESS: Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51484 ✓ E 51484

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 7 S. Stockton ST. 18-29 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Willis

(a) RESIDENCE NO. 7 S. Stockton ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Willis

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Demurrny Co. Virginia

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Albert Jenkins

(Address): 7 S. Stockton

15 Filed DEC 1 - 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-28-29

17 I HEREBY CERTIFY, That I attended deceased from 11-22-1929 to 11-28-1929 that I last saw h[illegible] alive on 11-28-1929 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John E. F. Campy, M. D.

. 19 (Address) 724 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Dec 1, 1929

20 UNDERTAKER: Mr. Cates R. Williams — ADDRESS 3225 Schroeder St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51485

CERTIFICATE OF DEATH

32 ✓

E 51485

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 4-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Sellies

(a) RESIDENCE NO. 226 N Bruce St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Sellies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Colburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant James Sellies

(Address) 226 N Bruce St

15 Filed DEC 1 1929 H. Lee Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Nov 30, 1929, that I last saw her alive on Nov 30, 1929 and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Meningitis (Tuberculous)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lumbar puncture

(Signed) Myron G Tull, M. D.

12/1, 1929 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Dec 1 1929
20 UNDERTAKER	ADDRESS
Joseph A. Lively	4021 Mount St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

John Baranowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51486

CERTIFICATE OF DEATH.

74-001 E 51486

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. W. B. & A. Station, St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Baranowski

(a) RESIDENCE NO. 245 S. Washington St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sophie Baranowski

6 DATE OF BIRTH (month, day, and year) Dec-24/1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Bowie Race Track

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Martin Baranowski

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Rozetta Glinska

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Sophia Baranowski

(Address) 245 S. Washington Street

15 Filed DEC 1 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Eugene Zillert, M. D. (Coroner)

11/30 29 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery Date of Burial Dec/3 1929.

20 UNDERTAKER George A. Weber ADDRESS 206 S. ann st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—816-19-4-27—100 Bks.

E 51487

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51487

CERTIFICATE OF DEATH

118-09

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3002 Erdman Ave WARD) 8-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Bernard Grauer

(a) RESIDENCE NO. 3002 Erdman Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15. 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adolph T. Grauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary A Loftus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Adolph T. Grauer

(Address) 3002 Erdman Ave

15 Filed OCT 1 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1929, to Nov. 30, 1929, that I last saw him alive on Nov. 29, 1929 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intussusception

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Eugene L. Pessagno, M. D.

Nov. 30 1929 (Address) 5-14 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cem

DATE OF BURIAL Dec 2. 1929

20 UNDERTAKER John Ulrich

ADDRESS 201 E Oliver

GIVE B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E. 51488

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51488

CERTIFICATE OF DEATH

129

[redacted]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2832 Harlem Ave. ST. 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Hood

(a) RESIDENCE NO. 2832 Harlem Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William Hood

6 DATE OF BIRTH (month, day, and year) August 1, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomack County Virginia

PARENTS

10 NAME OF FATHER Thomas Hickman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Miss Mamie E. Hood

(Address) 2832 Harlem Avenue

15 Filed DEC 1 - 1929 C. HAMPSON MAILS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1927. to Nov 29. 1929.

that I last saw her alive on Nov 29. 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchu-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis hypertension chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Ed. Wessig M. D.

. 19 (Address) 4000 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec. 2 1929

20 UNDERTAKER Ralph J. Cook

ADDRESS 1003 West Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E-51489 · E [redacted]

E-51489 ✓ [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3125 Cliftmont ST., 8-4 (WARD)

2—FULL NAME John D. Hurm

(a) RESIDENCE NO. 3125 Cliftmont ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

6 DATE OF BIRTH (month, day, and year): May 1874

7 AGE: Years 55 | Months 6 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Inasmuch Mission

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jacob Hurm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Pa.

12 MAIDEN NAME OF MOTHER: Catherine Bopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Jos. Bagne

(Address) 3128 Cliftmont ave.

15 Filed DEC 1 1929 H. HAMPSON GIBBS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1929, to Nov. 29, 1929, that I last saw him alive on Nov. 28, 1929, and that death occurred, on the date stated above, at 7-45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 601 W. Saratoga St

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) W. S. Franklin, M. D.

, 19 (Address) 92 Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. A.A. | DATE OF BURIAL: Dec 2. 1929

20 UNDERTAKER: Margaret L. Flynn | ADDRESS: 422 Light St.

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 51490

REGISTERED NO. 100-001 E 51490

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 15-63 (WARD)

2—FULL NAME George Coster

(a) RESIDENCE NO. 3816 Wk Garrison ST., Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Alverda Coster

6 DATE OF BIRTH (month, day, and year): Aug 24-1852

7 AGE: Years 77 | Months 3 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None — 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Coster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Ellen Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Friends — (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 1 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 30-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929, to Nov. 30, 1929

that I last saw h. alive on Nov. 30, 1929

and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) E. E. Jones, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec 3 19 29

20 UNDERTAKER: Hughes & Jones Inc — ADDRESS: 1st & N Bway

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57491

E 57491

E 57491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-09

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1611 ST., E. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles F Stewart

(a) RESIDENCE NO. 1707 Fairmount Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of E. V. Stewart

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamfitter

(b) General nature of industry, business, or establishment in which employed (or employer) " 060

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Va.

PARENTS

10 NAME OF FATHER W. F. Stewart

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER B. C. Powell

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records
(Address)

15 Filed DEC 1 - 1929 A. M. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-29

17 I HEREBY CERTIFY, That I attended deceased from 11-29, 1929, to 12-1, 1929,

that I last saw h. alive on 12-1, 1929

and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. & Path. Lab.

(Signed) Marion W. McLean, M. D.

12-1, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL, CREMATION~~ OR REMOVAL	DATE OF BURIAL
Washington D. C.	12/1 1929
20 UNDERTAKER Wm. H. Sando & Co	ADDRESS 412 N. St N.W.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51492.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51492

CERTIFICATE OF DEATH

143-00 E 51492

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St., or Ward) 10-69

2-FULL NAME Vere Virginia Jones

(a) RESIDENCE No. 2564 W. Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry

6 DATE OF BIRTH (month, day, and year) Dec 2-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28	— 11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Tyrone Pa.
(State or country)

PARENTS

10 NAME OF FATHER Elton Holliday.

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country) "

12 MAIDEN NAME OF MOTHER Nellie Higgins

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Harry Jones
(Address) 2564 W Baltimore

15 Filed DEC 2 - 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 29-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Miscarriage. due to accident

(duration) ..... yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of .....

Was there an autopsy? No Surg. Examination

What test confirmed diagnosis? Regular

(Signed) F. Bell Leach, M. D.

(Address) Coroner

Nov 29/1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN CEM	DEC 2 1929
20 UNDERTAKER ROBERT BROOKSSON	ADDRESS CALHOUN HOLLINS STS

Spec.—2-29-28—L. F. S.—500 Bks.

98158 3

E 51493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51493

REGISTERED NO. 74001 65 1493

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16-27 WARD)

2—FULL NAME Annie Green Roberts

(a) RESIDENCE NO. 1615 Harlem ST., St— WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Roberts -

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	47+			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va -

PARENTS

10 NAME OF FATHER Isaac Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Francis Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 2 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-29-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Nov 29, 1929, that I last saw her alive on Nov. 29, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Subarachnoid hemorrhage

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension

..... (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological findings

(Signed) Hedwig Kuessig, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 2, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 3227 Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51494

E 51494

E 51494

CERTIFICATE OF DEATH

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1510 N. Gilmore St., 19-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Miller

(a) RESIDENCE NO. 1405 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1894

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
35	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ridge

(State or country) Md.

PARENTS

10 NAME OF FATHER Lewis A. Miller

11 BIRTHPLACE OF FATHER (City or town) Hardsville

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia A. Jones

13 BIRTHPLACE OF MOTHER (city or town) St. Inigoes

(State or country) Md.

14 Informant Charles M. Miller

(Address) 732 P. St. N.W. Washington, D.C.

Filed DEC 2 - 1929 HAMILTON JONES, Registrar

BY PMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929 to Nov 28, 1929

that I last saw her alive on Nov 27, 1929

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Multinodular fibroid uteri & cystic Ovaries

Duration

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Nov 25/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. O. Hughes M. D.

Nov 28 1929 (Address) 1413 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Peter's Cemetery	Dec. 2, 1929

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 Schroeder St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51495

CERTIFICATE OF DEATH

74-092

E 51495

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO. 90-10

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philip Beckman

(a) RESIDENCE NO. 3037 Frederick Ave. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth ? yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Rudolph Beckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna De Graff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1928, to Nov. 29, 1929, that I last saw him alive on Nov. 29, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Thrombosis of rt middle cerebral artery

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension; Arteriosclerosis over

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Aut. P.C. Autopsy

(Signed) Theron F. McLean M. D.

12-1, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 12/2 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51496

CERTIFICATE OF DEATH

E 51496

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 E 22nd St. WARD) REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Luke Swift Jr.

(a) RESIDENCE NO. 436 E. 22nd St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Swift

6 DATE OF BIRTH (month, day, and year) Sept 13, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boy Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. J. Swift & Co. Inc

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Luke Swift Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Jane Swift

(Address) 436 E 22nd St

15 Filed DEC 2 - 1929 19 H. M. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1929, to Dec. 1, 1929, that I last saw h[e] alive on Nov. 30, 1929 and that death occurred, on the date stated above, at 4:20 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Chronic Interstitial Nephritis

Hypertension & Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Right Foot

(duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Lucius E. Jaka, M. D.

19 (Address) 515 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Cathedral	12/4 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51497 — 38 — E 51497

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto city Hosp. ST. 97-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Carkenter

(a) RESIDENCE NO. 816 S. Sharp ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Benjamin Carpenter

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Betty Law?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

14 Informant Records

(Address)

Filed DEC 2 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-29

17

I HEREBY CERTIFY, That I attended deceased from 5-24, 1929, to 11-27, 1929, that I last saw h.. alive on 11-27, 1929 and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, Rt.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic & acute: Ag. Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin: C.C: Lab: Wass

(Signed) Marvin M. McLean, M. D.

11-28, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	12-3 1929
20 UNDERTAKER John H. Tradum	ADDRESS 1027 Hull St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 51498

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51498

CERTIFICATE OF DEATH.

REGISTERED NO. 129 E 51498

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 W Saratoga ST. 19-26 WARD)

2-FULL NAME William Henry Walker

(a) RESIDENCE No. 1312 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C of	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene D Walker

6 DATE OF BIRTH (month, day, and year) June 11 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing Machine Adjuster 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Singer Manufacturing Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William H Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Sample

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Irene D Walker

(Address) 1312 W Saratoga

15 Filed DEC 2 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/30 1929 to 11/29 1929, that I last saw him alive on 11/28 1929, and that death occurred, on the date stated above, at 6 A/ m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis and nephritis.

(duration) — yrs. 4 mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urine + Blood Pressure

(Signed) [illegible] M. D.

11/30 1929 (Address) 1312 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 12-2 1929

20 UNDERTAKER [illegible] — ADDRESS 1027 Druid Hill

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51499

CERTIFICATE OF DEATH

3/V E 51499

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Rogers

(a) RESIDENCE NO. Loney's Lane near Brehm's ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Aug 23, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Rodgers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Mells

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

11 Informant Hospital Records
(Address)

15 Filed DEC 2 - 1929, 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Nov. 30, 1929, that I last saw h. im alive on Nov. 30, 1929 and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas. Thomas Jr. M. D.

11-30 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Dec 2, 1929

20 UNDERTAKER Robt L. Turner — ADDRESS 1411 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CERTIFICATE OF DEATH

#51500

REGISTERED NO. 51500

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

BALTIMORE: (No. 2039 E. Balto. St. WARD)

2—FULL NAME Morris Sawnick Sawnick

(a) RESIDENCE NO. 2039 E Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR ... N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMA... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Sawnick

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 Eastern Ave.

15 Filed DEC 2 - 1929 C. HERBERT JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Dec 2, 1929, that I last saw him alive on Dec 2, 1929, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jacob Cohen, M. D.

Dec 2, 1929 (Address) 2235 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 12-2-1929

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

Spec.—1-10-21—MAT—1500 Blks.

E 51501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1222 E 51501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W. Cross ST., 21-31 WARD)

2-FULL NAME Kate Dunn Harrison

(a) RESIDENCE NO. 532 W Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Brown Harrison

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Powhatan Co. Virginia

PARENTS

10 NAME OF FATHER: James Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Powhatan Co Virginia

12 MAIDEN NAME OF MOTHER: Louise —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Viola Dunn 532 W Cross

15 Filed 1929, 19 Registrar

H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/20 1929

17

I HEREBY CERTIFY, That I attended deceased from 10/11, 1929, to 11/20, 1929, that I last saw h[illegible] alive on 11/20 1929, and that death occurred, on the date stated above, at 11-4 a m.

The CAUSE OF DEATH* was as follows:

Hemmorhages - gastric -

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis

(duration) 4 yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dan Trundle, M. D.

11/20, 1929 (Address) 122 W Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Dec 2 1929

20 UNDERTAKER: C L Brown & Son

ADDRESS: 1011 N Mond[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

FC 2 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51502

106-001

CERTIFICATE OF DEATH

E 51502

1—PLACE OF DEATH Balto City Hospls — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md. ST 2331 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Gross

(a) RESIDENCE NO. 1005 Leadenhall ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hosps Rec
(Address) Balto Md

15 Filed DEC 2 1929, H. LAWRENCE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-29

17

I HEREBY CERTIFY, That I attended deceased from 4-16-, 1928, to 11-30, 1929, that I last saw him alive on 11-29-, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia
Myocardial Failure
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis c Hypertension v Cerebral Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Harry J. Corbett, M. D.

11-30, 1929 (Address) Balto city Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem — DATE OF BURIAL Dec 3 1929

20 UNDERTAKER L. A. Brown & Son — ADDRESS 616 W Fayette

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51503

E 51503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51503

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4218 Dillon ST. 26-41 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Hoffman

(a) RESIDENCE NO. 4218 Dillon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb 16 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs M Parr.

(Address) 4218 Dillon st.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1929 to Nov 29th 29 that I last saw h... alive on Nov 29th 29 and that death occurred, on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Senility Stenosis Valvular Mitrale

Coronary Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

*Was there an autopsy?

What test confirmed diagnosis?

(Signed) P O Stoner M. D.

Dec 1, 1929 (Address) 4900 Dolan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Dec 3 1929

20 UNDERTAKER Geo. A. Ruth — ADDRESS 1735 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 2 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51504

CERTIFICATE OF DEATH

12-29

E 51504

1—PLACE OF DEATH

REGISTERED NO. 76-39

CITY OF BALTIMORE: (No. 150 N. Haven ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah E. Sparr.

(a) RESIDENCE NO. 150 N. Haven st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Sparr.

6 DATE OF BIRTH (month, day, and year): August 9 1871

7 AGE: Years 58 | Months 3 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: H. W. Shuard.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: E. Sanckler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John A. Sparr.

(Address): 150. N. Haven st

15 Filed: DEC 2 - 1929 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-1-29

17

I HEREBY CERTIFY, That I attended deceased from aug 1 29 to 12-1-29

that I last saw h. alive on 12-1-29

and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH was as follows:

Nephritis Hypertension

arteriosclerosis

apoplexy. 4 mo.

CONTRIBUTORY (Secondary) duodenal Carcinoma Pulmonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gunder

(Signed) J. W. Redding M.D.

12-1-29 (Address) 501 N. Patterson Park

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County

DATE OF BURIAL: 12/4 1929

20 UNDERTAKER: Lyons - L. Ruth

ADDRESS: 1730 Harlem Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 51505 HEALTH DEPARTMENT—CITY OF BALTIMORE

88 E 51505

CERTIFICATE OF DEATH

REGISTERED NO. 8-16

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Conklin

(a) RESIDENCE NO. 1678 N. Montford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Conklin

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman in Metal

(b) General nature of industry, business, or establishment in which employed (or employer) factory

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Harry C. Conklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Langley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Conklin

(Address) 1628 N. Montford ave

15 Filed DEC 2 - 1929 H. M. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Nov 29, 1929,

that I last saw h(M) alive on Nov 29, 1929

and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

Vegetative form -

Septicaemia -

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes — Gave by diptheria culture & gloves

What test confirmed diagnosis? Clinical & Laboratory

(Signed) W. O. Draper, M. D.

11-29, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 3 1929
20 UNDERTAKER	ADDRESS
Geo. L. Ruth	1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor. 10-10-29 A Co. 100 Blks.

Harry L. Aull

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51506

166

E 51506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 27-42 Ward)

2-FULL NAME Harry L. Aull

(a) RESIDENCE NO. 3804 Pinewood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carlotta A. Aull

6 DATE OF BIRTH (month, day, and year) Dec 29/1906

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	22	11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) 029
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Herbert W. Aull

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER L. Estelle Righter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Herbert W. Aull
(Address) 3804 Pinewood Ave

15 Filed ..... 19.. C. H. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bicloride Mercury Poisoning
(Suicide)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes. St. Joseph Hosp.

What test confirmed diagnosis?

(Signed) [signature] M. D.

11/30/29 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Dec 1929

20 UNDERTAKER W. M. Routson

ADDRESS 2230 Pa Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 2 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51507

CERTIFICATE OF DEATH

129 E 51507

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N. Linwood Ave WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Etta Rollison

(a) RESIDENCE NO. 205 N. Linwood Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed or divorced, HUSBAND of (or) WIFE of Wm. C. Rollison

6 DATE OF BIRTH (month, day, and year) Aug 26 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	~~58~~	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Baltimore Co Md.

PARENTS

10 NAME OF FATHER Thos Beaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Beaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm C. Rollison

(Address) 205 N. Linwood Ave.

15 Filed DEC 2 1929 HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29/29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1929, to Nov. 29, 1929, that I last saw her alive on Nov. 27, 1929, and that death occurred, on the date stated above, at 10:50 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

CONTRIBUTORY (Secondary) Chronic Diabetes (duration) yrs. 4 mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Last known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Ross Jamison, M. D.

11-30-29 (Address) 2938 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem DATE OF BURIAL Dec 2 1929

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51508

188-103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 15-23 Franklin Sq Hos (St.) (Ward)

2-FULL NAME Hezkiah Williams

(a) RESIDENCE NO. 1359 Woodyear St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Williams

6 DATE OF BIRTH (month, day, and year): Nov 27 - 1889

7 AGE: Years 40 | Months | Days 13 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Steerdor
(b) General nature of industry, business, or establishment in which employed (or employer): Shipping
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Hezkiah Williams

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Harriet Walker

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Va

14 Informant: Susie Williams
(Address) 1539 Woodyear St

15 Filed ....., 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Fract Skull
Run down by auto at
street crossing
ac (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fulton & Lauren

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. D. Stamm, M. D.

11/30 1929 (Address) 2934 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: D 2 1929

20 UNDERTAKER: Thomas E Kelson

ADDRESS: 1303 Pennsylvania Ave

DEC 2 1929 G. H. SHOOP MOS. PRINTING CO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51509 90 ✓ E 51509

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 1523 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Dyson

(a) RESIDENCE NO. 1325 Presstman St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 2 - 1929

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosian Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929 to Nov. 23, 1929, that I last saw her alive on Nov. 23, 1929 and that death occurred, on the date stated above, at 4:55 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia, Septicemia (source undetermined)

(duration) ..... yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Tonsilitis

(duration) ..... yrs. mos. 35 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.C. Lab. autopsy

(Signed) Harvey W. McLean, M. D.

11-30, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec. 2 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1325 Presstman St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51510

E 51510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital (St.) 2027 (Ward)

2-FULL NAME John J. McKenna

(a) RESIDENCE NO. 1909 W Fairmount Ave (St.) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary McKenna

6 DATE OF BIRTH (month, day, and year) Dec 25th 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Coal Engraded Co

9 BIRTHPLACE (city or town)
(State or country) Ireland.

PARENTS

10 NAME OF FATHER John McKenna

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mrs Mary McKenna.
(Address) 1909 W Fairmount Ave

15 Filed DEC 2 - 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: (Probable) Fractured Skull And internal injuries Caused by accidentally being thrown in some machinery at Coal Co

(duration) yrs. mos.

CONTRIBUTORY (Secondary) About 20 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Illig. M. D.

Dec. 1929 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Dec 3rd 1929

20 UNDERTAKER John J. Cowen & Son

ADDRESS 901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—10-10-29—A Co.—100 Bks.

Brooks

E 51511

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 51511

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Baby" Brooks

(a) RESIDENCE NO. 1131 E. Lexington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23/29

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Brooks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Bertha Cooper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Bertha Brooks
(Address) 1131 E. Lexington

15 Filed DEC 2 1929 H. M. JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Cannon, M. D.

12/2/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery

DATE OF BURIAL 12/2 1929

20 UNDERTAKER Mrs N A Elliott

ADDRESS 1725 Ashland ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51512

CERTIFICATE OF DEATH

90 E 51512

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 707 N. Milton Ave St. 7-12 Ward)

2-FULL NAME Marie Agnes Kaufmann

(a) RESIDENCE NO. 707 N. Milton Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry J. Kaufmann

6 DATE OF BIRTH (month, day, and year) April 6, 1838

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	91	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Christian G. Gerber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Fredericka Spick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Charles W. Kaufmann
(Address) 707 N. Milton ave

15 Filed DEC 2 - 1929 19.. THAMES JONES, J. P. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said I (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. H. Oan, M. D.

Dec. 1, 1929 (Address) 508 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Dec 2 - 1929
20 UNDERTAKER Bertram E. Love	ADDRESS 1122 W Lafayette ave

FEB. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51513

CERTIFICATE OF DEATH

100-001

E 51513

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 130 E. William St. WARD) 4-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris D. Moran

(a) RESIDENCE NO. 130 E. William ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Daughter

6 DATE OF BIRTH (month, day, and year) Sept 26 1928

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	1	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rebecca Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co Md

14 Informant Mrs Rebecca Moran

(Address) 130 E William St

15 Filed DEC 2 - 1929 C. H. JOHNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929 to Nov 30, 1929

that I last saw her alive on Nov 30 1929

and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 14 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. R. L. Campbell M. D.

Nov 30 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side fur additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Chapel Kent Co Md — DATE OF BURIAL Dec 3 1929

UNDERTAKER Charles L Stevens — ADDRESS 150 E Fort Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51514 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51514

2314

CERTIFICATE OF DEATH

101-00

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Harvey

(a) RESIDENCE NO. 311 West Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rebecca

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Albert Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mourning Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 2 - 1929 19... H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 29 1929

17 I HEREBY CERTIFY, That I attended deceased from November 23 1929 to November 29 1929, that I last saw h.~~im~~ alive on November 29, 1929 and that death occurred, on the date stated above, at 5 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture post mortem findings

(Signed) Ludwig Kreeger, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Dec 2 1929

20 UNDERTAKER Earl T. Hemsley

ADDRESS 378 W Biddle St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51515

CERTIFICATE OF DEATH

187-007 E 51515

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital Ward) 24-33

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H, Lamb.

(a) RESIDENCE NO. Walkerville Ontario, Canada. St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. / ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 29, 1905

7 AGE	Years	Months	Days	IF LESS than 1 day .. hrs. or .. min.
	24	8	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor, 086
(b) General nature of industry, business, or establishment in which employed (or employer) S/Stomalvo.
(c) Name of employer

9 BIRTHPLACE (city or town) England.
(State or country)

PARENTS

10 NAME OF FATHER Elson Lamb.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England.

12 MAIDEN NAME OF MOTHER Caroline White.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) England.

14 Informant Caroline Lamb. (mother)
(Address) Walkerville, Ontario, Canada.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

DEC 2 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Caught in a hoisting winch.

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Pier 8 Port Covington
Nov. 29, 1929

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Fernlandt, M. D.

12/2, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL
WALKERVILLE, ONT. Via Railway Express Agency Inc.

DATE OF BURIAL Dec 2 1929

20 UNDERTAKER John P. Denny

ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Blks.

Lanham.

E 51516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 113 E 51516

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument or Rutland St.) 1-13 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Howard Lanham

(a) RESIDENCE NO. 6910 Fenway ST. Lorraine Park WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) July 23 1929

7 AGE: Years — Months 4 mo — Days 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Howard P. Lanham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Newport News Va

12 MAIDEN NAME OF MOTHER: Bessie McDonley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Mr Howard P Lanham 6910 Fenway

15 Filed DEC 2 - 1929 Registered C. HAMPSON JONES, M. D. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/25, 1929, to 11-29, 1929, that I last saw him alive on 11-29, 1929, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

acute entero colitis

(duration) yrs. mos 39 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? lab + physical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Dec 2 1929

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51517

CERTIFICATE OF DEATH.

1929 E 51517

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 Pennsylvania Ave (St.) (WARD)

2-FULL NAME Sarah Elizabeth ~~Kerns~~ Kerns

(a) RESIDENCE NO. 813 Pennsylvania Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Wm A Kerns

6 DATE OF BIRTH (month, day, and year): May 30, 1874

7 AGE: 55 4/12 — Years: 55 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N Work

(b) General nature of Industry, business, or establishment in which employed (or employer): N Work

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Belfast Ireland

PARENTS

10 NAME OF FATHER: Michael Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belfast Ireland

12 MAIDEN NAME OF MOTHER: Sarah McGarvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belfast Ireland

14 Informant (Address): Husband Wm Kerns 813 Pennsylvania Ave

15 Filed ....., 19.... C. HERBERT JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Nov 30, 1929, that I last saw h[illegible] alive on Nov 30, 1929, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: Acute dilatation of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis, Bronchitis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical findings

What test confirmed diagnosis?

(Signed) J. J. MacMurchy M. D.

, 19 (Address) 2147 Hilford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: Dec 1929

20 UNDERTAKER: John Fields — ADDRESS: 200 W Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

E 51518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51518

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Rutland St., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Gillian

(a) RESIDENCE NO. 905 Rutland ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	c	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Maggie Gillian

6 DATE OF BIRTH (month, day, and year) — — 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Newberry
(State or country) S. C.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant John Gillian (son)
(Address) 905 Rutland

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28. 29

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov. 28, 1929, that I last saw h— alive on Nov. 28, 1929, and that death ocrurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Uremia, Auto-intoxication

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbia Dale	Dec. 2 1929
20 UNDERTAKER	ADDRESS
Mrs. P. C. Elliott	1725 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51519 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51519

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 367 E. Ash St (St.) 13-57 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Keitha Ray Reed.

(a) RESIDENCE No. 367 E Ash St (St.) ..... (Ward) .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22/1929.

7 AGE — Years: 0 — Months: 1. — Days: 9 — If LESS than 1 day..... hrs. or..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country) Md.

PARENTS

10 NAME OF FATHER Elbert B. Reed.

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Blanche M. Richardson

13 BIRTHPLACE OF MOTHER (city or town) Union Bridge (State or country) Md

14 Informant Elbert B. Reed. (Father)
(Address) 367 E. Ash St.

15 Filed DEC 2 1929 19 C. HAMPSON JONES, M. D.
Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1929, to Dec 1, 1929, that I last saw he alive on Dec. 1, 1929 and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Bilateral Bronchial Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. H. Jones, M. D.

12/1, 1929 (Address) 9 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — DATE OF BURIAL: 12/3/29

20 UNDERTAKER: Walter Davis — ADDRESS: 33 Pine St

I. WRITE PLAINLY, WITH UNFADING INK. THIS STATEMENT IS A RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51520

CERTIFICATE OF DEATH.

11 E 51520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. W WARD)

2-FULL NAME Josephine Rakowski

(a) RESIDENCE No. 1600 Aliceanna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bronislaus Rakowski

6 DATE OF BIRTH (month, day, and year) Oct 29 1888

7 AGE Years 41 Months 1 Days 2 If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stanislaus Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Veronika Koprowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital records. (Address)

15 Filed DEC 2 1929 19... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-17 1929 to 12-1 1929.

that I last saw her alive on 12-1 1929

and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos 14 da.

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 11-20-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Hendrix, M. D.

19 29 Address 1600 Aliceanna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Dec. 4 1929

UNDERTAKER: John M. Weber ADDRESS: 401-A Chester

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51521

CERTIFICATE OF DEATH

90 ✓

E 51521

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3524 GREENMOUNT ST. 12-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CLARA LOUISA SCHULTZE

(a) RESIDENCE NO. 3524 GREENMOUNT AVE. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Fem.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William J. Schultze

11 BIRTHPLACE OF FATHER (city or town) Braunschweig (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs. Ida Kloch

(Address) 2110 N. Calvert St.

15 Filed DEC 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1929, to Dec. 1, 1929, that I last saw h[illegible] alive on Dec. 1, 1929, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. 8 mos. 26 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John K. Abercrombie, M. D.

Dec. 1, 1929 (Address) 574 Graumont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Dec 3 1929
20 UNDERTAKER	ADDRESS
Chas. E. Sauerwald	802 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 51522

REGISTERED NO. 2050

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Stricker ST. 11-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Mae Roundtree

(a) RESIDENCE NO. 531 Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. 4 How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 25/29.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Roundtree

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tazewell County Va.

12 MAIDEN NAME OF MOTHER Martha Jamison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kingsdale W. Va.

14 Informant Father Thomas Roundtree

(Address) 531 Stricker

15 Filed DEC 2 1929, H. J. JONES, M. D. Registrar

per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29/29

17 I HEREBY CERTIFY, That I attended deceased from 11/29/29, 19..., to ..., 19..., that I last saw her alive on 11/29/29, 19..., and that death occurred, on the date stated above, at 11 o'clock A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ✓ ✓ one yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles days according to history

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) W. B. Parkesdale M. D.

11/30/1929 (Address) 546 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 12-2 1929

20 UNDERTAKER Chas G. Cooper — ADDRESS 514 N. Calhoun St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51523

CERTIFICATE OF DEATH.

161-081

E 51523

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 Bartlett Ave ST. 9-46 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hertz

(a) RESIDENCE NO. 708 Bartlett Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) 11/28/29

7 AGE — Years: ~~1 day~~ | Months: | Days: 2 | If LESS than 1 day 4 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lewis Hertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Anna Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant ...
(Address)

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

4148

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30 19 29

17 I HEREBY CERTIFY, That I attended deceased from 11/28 , 19 29 , to 11/30 , 19 29 that I last saw h[illegible] alive on 11/30 , 19 29 and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Prematurity 5½ mos utero

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Roentgen 5½ mos

(Signed) Chas A Cullen M. D.

12/1, 19 29 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19 DEC 2 1929

20 UNDERTAKER Commissioner

ADDRESS ...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

424

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 51524

CERTIFICATE OF DEATH

E 51524

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Dillon St. ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mc Andrew

(a) RESIDENCE NO. 3105 Dillon St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Canton Box Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Mc Andrew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hanora Mc Andrew

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Elsner

(Address) 3105 Dillon St

Filed DEC 7 - 1929 15 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 29

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Nov 29, 1929, that I last saw h[illegible] alive on Nov 29, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/30, 1929 (Address) 1014 S Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec. 3, 1929

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51525

CERTIFICATE OF DEATH

100-081

E 51525

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 114 S Bethel St. 2-H Ward)

2-FULL NAME Walter Ruffin

(a) RESIDENCE NO. 114 S Bethel St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 rs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Francis Ruffin

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) N C

PARENTS

10 NAME OF FATHER Solomon Ruffin

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) N C

12 MAIDEN NAME OF MOTHER Sallie Power

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) N C

14 Informant J Bengson autonart
(Address) 114 S. Bethell St

15 Filed C 2 - 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) C L Lawson

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Med History

(Signed) C. Slade, M. D.

19 (Address) 43 [illegible] Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	Dec 2 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51526

CERTIFICATE OF DEATH

90

E 51526

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2047 E. Monument St. 6-9 Ward)

2-FULL NAME Celeste E. Dotterer

(a) RESIDENCE NO. 234 N. Chester St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. H. Dotterer

6 DATE OF BIRTH (month, day, and year) Aug 31/1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	47	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Marian A. Downs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Clara A. Francis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Wm. H. Dotterer
(Address) 234 N. Chester St

15 DEC 2 - 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Jos. Carr, M. D.
12/2/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Dec. 3 1929

20 UNDERTAKER Wm. E. Black ADDRESS 922 N. Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51527

CERTIFICATE OF DEATH

E 51527

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. South Baltimore General Hospital Orion 24-33 Ward)

2-FULL NAME Louis F. N. Smith.

(a) RESIDENCE NO. Green Haven A.A.Co.Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 7, 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	22	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician.
(b) General nature of industry, business, or establishment in which employed (or employer) 029
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER George A. Smith.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington, D.C.

12 MAIDEN NAME OF MOTHER Lucia E. Pumphrey.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant George A. Smith. (father)
(Address) Green Haven A.A Co. Md.

15 Filed ....., 19.... C. HARRISON JONES, Registrar
DEC 2 1929
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol shot wound in the heart. Suicide. Death occurred at Green Haven A.A.Co.Md. and inquest held by Coroner Everd.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Green Haven A.A.Co.Md
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto M. Steinhardt, M. D.
12/2, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec. 4 1929

20 UNDERTAKER Joseph H. Cook — ADDRESS 1003 West Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51528

CERTIFICATE OF DEATH

161-001 E 51528

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3516 Clipper Rd ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Schmeltz

(a) RESIDENCE NO. 3516 Clipper Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-29-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	2 #	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto - md
(State or country)

PARENTS

10 NAME OF FATHER Peter Schmeltz

11 BIRTHPLACE OF FATHER (city or town) Wheeling
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Margaret Payne

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant (Mother) Margaret Schmeltz

(Address) 3516 Clipper Rd.

DEC 2 1929 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-29

17 I HEREBY CERTIFY, That I attended deceased from 11-29, 1929, to 12-1, 1929, that I last saw h[illegible] alive on 11-29, 1929, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Alexander Harvey, M. D.

12/1, 1929 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec. 2 1929

20 UNDERTAKER: Joseph Cook — ADDRESS: 1003 West Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Rev.—d-12-23—M&T—500 Bks.

E 51529 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51529

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp ST. 20-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna E Sanders

(a) RESIDENCE No. 2666 Lehman St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L Sanders

6 DATE OF BIRTH (month, day, and year) Nov 3rd 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Priv. Fy.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant (Son) Harry Sanders Jr (Address) 2666 Lehman St

15 Filed Dec 2 1929 C. HAMPSON JONES, M. D. Registrar

C 2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 30, 1929, that I last saw h er alive on Nov 30, 1929 and that death occurred, on the date stated above, at 3.00 A m

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, arterio sclerosis complicated by infected Gangrene of foot

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Nov 27, 1929

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Dec 3rd 1929

20 UNDERTAKER H. B. Hepburt — ADDRESS 1850 N Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Wm 1216 N Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51530

CERTIFICATE OF DEATH

24-001

E 51530

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella K. Russell

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Russell

6 DATE OF BIRTH (month, day, and year): Jan 10th 1848

7 AGE: Years 81 80 | Months 10 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington

PARENTS

10 NAME OF FATHER: John Tonge

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Margaret Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Little Sisters of the Poor
(Address) Preston & Valley St

15 Filed ... 19... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2nd 1929

17

I HEREBY CERTIFY, That I attended deceased from 11/30, 19 24, to 12/2, 19 29,

that I last saw h alive on 12/2, 19 29

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Benevolent M. D.

12-2, 29 (Address) 1216 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 12/4 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 S Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

C 2-1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51531

REGISTERED NO. E 51531

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Maryland Gen Hospital St., 15-21 Ward)

2-FULL NAME David C Lee

(a) RESIDENCE NO. 1712 West North Ave St.,

(Usual place of abode) Ward

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): July 28 1853

7 AGE: Years 46 Months 4 Days 3 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Emory T. Lee

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary King

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md

14 Informant: Mrs Lyda L Warner
(Address) Towsontown Md

15 Dec 1 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1st 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Own dose Paraldehyde
(Accident.)
(duration) yrs. mos. Chronic

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physician
(Signed) Ed Fink Coroner, M. D.
Dec 1/29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 12/3 1929

20 UNDERTAKER: William Cook — ADDRESS: 127 St Paul St

C. E.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 E 51532 84 E 51532

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Dr Gee M Lee

(a) RESIDENCE NO. 1630 Fillmore St ST., WARD

(Usual place of abode) Walbrook Md

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/25/76

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) Ors

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address)

15 Filed ..... 19 ..... Registrar

DEC 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Dec 1, 1929, that I last saw h... alive on Dec 1, 1929 and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Glioma, Benign

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 24. XII. 29

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E H Campbell M. D.

12/1/29 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton Elkton Md	Dec 4 19 29
20 UNDERTAKER Wm L Tuttle	ADDRESS Rising Sun Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 51533

CERTIFICATE OF DEATH

E 51533

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2943 Clifton Ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Rebecca Jones

(a) RESIDENCE NO. 2943 Clifton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard H. Jones

6 DATE OF BIRTH (month, day, and year) Mar. 16-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Michaels Md

PARENTS

10 NAME OF FATHER Jas. H. Wharton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta M. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. J. Jones

(Address) 3136 Leeds Ave

15 Filed DEC 3 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1- 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24th, 1929, to Dec 1st, 1929, that I last saw her alive on Dec 1st, 1929 and that death occurred, on the date stated above, at 5:40 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) Box 511 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels. Md	Dec 4 1929
20 UNDERTAKER	ADDRESS
Wm J. Tuckner & Sons	N. & Pa

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 11-001

E 51534

CERTIFICATE OF DEATH.

E 51534

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 Brentwood Ave Ward) 46-15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha R. Woolyhand

(a) RESIDENCE NO. 1008 Brentwood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Woolyhand

6 DATE OF BIRTH (month, day, and year) Aug 4/1874

7 AGE: Years 55 | Months 3 | Days 27 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Kent County Md.

PARENTS

10 NAME OF FATHER William Harris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Queen Anne County

12 MAIDEN NAME OF MOTHER Martha Gutteman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kent County Md.

14 Informant James Woolyhand

(Address) 1008 Brentwood Ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from NOV 22 1929, 19..., to DEC 1 - 1929, 19...,

that I last saw h.e.r. alive on DEC 1 - 1929, 19...,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Primal Carcinoma

(duration) 1 yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Involvement and Bronchial Pneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Chestertown Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Prof. Dulet, M. D.

19 (Address) 4256 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown Md Date of Burial Dec 4 1929

20 UNDERTAKER: Frank A. Fink ADDRESS 915 N. Gay St

DEC 3 1929 C. [illegible] REGISTRAR OF VITAL STATISTICS, Registrar

FC

Spec.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51535 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 51535

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1423 Jefferson ST. 5-9 WARD)

2—FULL NAME Marie Scott

(a) RESIDENCE NO. 1423 Jefferson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Sam Dunbrin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Norah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Norah Smith
(Address) 509 N. Bethel st

15 Filed DEC 3 1929 HARRISON JONES, M.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 9, 19 29, to Nov 29, 19 29, that I last saw h alive on Nov 29, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tb of anus

Contributory (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

, 19 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery — DATE OF BURIAL Dec 3 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

Information should be carefully supplied. NOTE should be taken that CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51536 E 51536

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 100

CITY OF BALTIMORE: (No. 3611 Roberts Place WARD 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Donald Bornschein

(a) RESIDENCE NO. 3611 Roberts Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 5 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 26 - 192

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adolph Bornschein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Adolph Bornschein

(Address) 3611 Roberts Place

15 Filed DEC 3 - 1929 H. L. PRICE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Dec 1, 1929, that I last saw him alive on Dec 1, 1929, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Measles

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Dr. D. Ellerson, M. D.

12/1/1929 (Address) 2307 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Dec 3rd 1929

20 UNDERTAKER John Geeries — ADDRESS 208 Caleans

IMPORTANT—Answers should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 51537 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 174-001 E 51537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mollie Kernan.

(a) RESIDENCE NO. Kent Co. Md. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Wm A. Kernan

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): State of Maryland Queen Anne Co

PARENTS

10 NAME OF FATHER: West

11 BIRTHPLACE OF FATHER (City or town) (State or country): Kent Mond

12 MAIDEN NAME OF MOTHER: Mollie West

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Mrs. Wm Tyler (Address) 1931 W North Ave.

15 Filed DEC 3 - 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929, to Dec. 2, 1929, that I last saw h alive on Dec, 1929 and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy.

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kent Co Md

DATE OF BURIAL: 12/3 1929

UNDERTAKER: W W Skinner

ADDRESS: 1150 Edmondson Ave

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 51538

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1022 McCulloh ST. 11-25 WARD)

2—FULL NAME Arthur M. Larkin

(a) RESIDENCE NO. 1022 McCulloh ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Larkin

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 37 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Lab

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Evansville Ind

PARENTS

10 NAME OF FATHER: Edward Larkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky

12 MAIDEN NAME OF MOTHER: Malcom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ky

14 Informant: Mamie Larkin

(Address) 1022 McCulloh St

FILED DEC 3 - 1929 C. HAMPSON JONES, Registrar

By EKE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Nov 30, 1929, that I last saw him alive on Nov 30, 1929, and that death occurred, on the date stated above, at 7-50 PM.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W M Hatcher, M. D.

11/1, 1929 (Address) 1122 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Dec 3 1929

20 UNDERTAKER: Samuel Hensley — ADDRESS 578 N Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51539

CERTIFICATE OF DEATH

1929 E 51539

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1900 Boone ST. 9-18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Frances Harker

(a) RESIDENCE NO. 1900 Boone ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E Harker

6 DATE OF BIRTH (month, day, and year) Nov 24-1848

7 AGE — Years 81 Months — Days 7 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John H Lyon

11 BIRTHPLACE OF FATHER (city or town) Glasgow
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliza Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country) Pa

14 Informant Miss Elaine Harker

(Address) 1900 Boone St

15 Filed DEC 3 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929, to Dec 1, 1929, that I last saw h alive on Dec 1 1929 and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis
Chr. Interstitial Nephritis
(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

Dec 2, 1929 (Address) 1100 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery. DATE OF BURIAL Dec 4 1929

20 UNDERTAKER Parham & Poe ADDRESS 1725 W Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Mills 90

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51540

CERTIFICATE OF DEATH

REGISTERED NO. E 51540

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 145 N. Potomac St., 6-11 Ward)

2-FULL NAME Joseph J. Mills

(a) RESIDENCE NO. 145 N. Potomac St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Mills

6 DATE OF BIRTH (month, day, and year) July 11/1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	71	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co.,
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph J. Mills

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Wolford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Joseph H. Brannock
(Address) 145 N. Potomac St

15 Filed DEC 3 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Odema Lungs-Cardiac Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos H Cain M. D.

12/3 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL 12/3 1929

20 UNDERTAKER William Cook

ADDRESS 121 St Paul

NOTICE PLEASE, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

51541

Morgan

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 51541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 12-50 Ward)

2-FULL NAME Annie Morgan

(a) RESIDENCE NO. 347 Ilchester Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George M. Morgan

6 DATE OF BIRTH (month, day, and year) May 19/1848

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	81	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Delohen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Warner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant William Cook
(Address) 1217 ST. Paul

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Fractured arm & shoulder.
(Accidently fell Inher home
Nov 24/29)

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Pace M. D.

12/3/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetary

DATE OF BURIAL 12/5 1929

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

DEC 1929

Star

INSTRUCTIONS—TYPEWRITER, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51542

Healy

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1/6/30 E 51542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 26-27 (Ward)

2-FULL NAME "Boy" Healy

(a) RESIDENCE NO. 413 Bonsal (South) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1/29

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Healy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Flaherty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Thomas Healy
(Address) 413 S. Bonsal

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity (about 7 mons Gest)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carter, M. D.

2/3/30 (Address) TPI 3. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL Dec 3rd 1929

20 UNDERTAKER Lilly & Geiler Inc

ADDRESS 409 S. Wolfe St

DEC 3 - 1929 HAMSON

Information, with CAUTION that THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Janyska.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51543

CERTIFICATE OF DEATH

155

E 51543

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 24-35 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie E. Janyska

(a) RESIDENCE NO. 1508 Latrobe Pk. Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 20 19[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Stanley Janyska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Bleem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Stanley Janyska.

(Address) 1508 Latrobe Pk Terrace

15 Filed C[illegible] 19[illegible] [illegible] Registrar

C 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-29

17 I HEREBY CERTIFY, That I attended deceased from 11-29, 1929, to 12-3, 1929, that I last saw h.[illegible] alive on 12-3, 1929 and that death occurred, on the date stated above, at 2 35 A m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis sacrum & ilium

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12-2-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical and operation

(Signed) J Leyko, M. D.

12/3, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	12-6 1929
20 UNDERTAKER	ADDRESS
E & B Hasle	1152 West St

IF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 51544

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 702 W. Fairmount St. 4th Ward)

2-FULL NAME Gloria E. Leonard

(a) RESIDENCE NO. 702 W. Fairmount St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
		6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Boynes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary E. Leonard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary E. Leonard
(Address) 702 W. Fairmount ave

15 Filed DEC 3 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Fellers M. D.

11/2, 1929 (Address) 2739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Dec 3, 1929

20 UNDERTAKER Joseph A. Lively — ADDRESS 709 N Mount st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-16-29—L. F. S.—100 Bks.

E 51545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 / E 51545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 N. Wolfe ST. 7-12 WARD)

2—FULL NAME Walter Johnson

(a) RESIDENCE NO. 933 N. Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Maggie McGruder

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mazie Johnson

(Address) 933 N. Wolfe St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Dec 1, 1929, that I last saw h[illegible] alive on Nov 30, 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Lobar

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

12-4, 1929 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 12-4 1929

20 UNDERTAKER Byrnes & Wright

ADDRESS 1218 Mc Elderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51546

CERTIFICATE OF DEATH

101-001

E 51546

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112-E-36- ST., 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline L. Phillips

(a) RESIDENCE NO. 1112-E-36½ ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 16 ds. How long in U. S., if foreign birth? 62 yrs. 10 mos. 16 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Phillips

6 DATE OF BIRTH (month, day, and year): January-15-1867

7 AGE — Years: 62 | Months: 10 | Days: 16 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Murray Blaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): ??? Ireland

12 MAIDEN NAME OF MOTHER: Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ??? Ireland

14 Informant: Mrs Jno. M. Sessions (daughter)

(Address) 2743 St. Paul St.

15 Filed DEC 3 - 1929, 19 ... or ... WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Dec. 1, 1929, that I last saw her alive on Dec. 1, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor L. Lam, M. D.

Dec, 1929 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Dec. 4 1929

20 UNDERTAKER: Stewart & Mooney Co — ADDRESS: Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89

E 51547

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 Cold Spring Lane ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Caslow

(a) RESIDENCE NO. 310 Cold Spring Lane ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Eli Caslow

6 DATE OF BIRTH (month, day, and year) March 21-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co. Pennsylvania

PARENTS

10 NAME OF FATHER Louis S. Bortner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Veranda E. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

M

Informant Eli Caslow

(Address) 310 Cold Spring Lane

15 Filed 1929 H. M. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1-1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29 1929, to Dec. 1 1929, that I last saw h alive on Dec. 1 1929 and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Porter, M. D.

12/2 1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 4-1929.
20 UNDERTAKER	ADDRESS
Horace F. Burgee	3631 Falls Road.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51548 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 29 E 51548

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4138 Roland Ave ST., 43-57 WARD)

2—FULL NAME Mary R. Seville

(a) RESIDENCE NO. 4138 Roland Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Seville

6 DATE OF BIRTH (month, day, and year) April 5-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Benjamin F. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Number

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Margaret M. Miller

(Address) 4138 Roland Ave

15 Filed DEC 3 1929 19 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1-1929

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Dec 1, 1929

that I last saw h[illegible] alive on Dec 1, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chron Dist Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? None.

What test confirmed diagnosis? Clinical

(Signed) Emmon J. Kelly, M. D.

12/7/1929 (Address) 608 Somerset Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenberry Cem. Perryman (Harford Co) DATE OF BURIAL Dec. 4-1929.

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Kelly Road

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

51549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 51549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Jail. St. 10-15 Ward)

2-FULL NAME Clyde E. Hayden.

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Captain Laville.
(Address) Baltimore City Jail.

15 Filed ..... 19 ..... Registrar

4121

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt M. D.

12/8 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL DEC 3 - 1929

20 UNDERTAKER Commissioner Health. 19

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

DEC 3 - 1929 JOHNS HOPKINS HOSPITAL

MORGUE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51550

CERTIFICATE OF DEATH

+ 188-203

E 51550

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hosp St., 7 5-72 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Mc Carthy

(a) RESIDENCE NO. Not known St., Ward

(Usual place of abode) (If non-resident give city or town and State) (supposed Bostonmass)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	dont know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of dont know

6 DATE OF BIRTH (month, day, and year) dont know

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	about 35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer) Marine
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) dont know

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont know

14 Informant
(Address)

15 Filed DEC 3 - 1929 Registrar

4122

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
struck & run down by auto on Wash Road. Labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hem.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash Rd at Lang

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Brown M. D.

12-2 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health
DEC 3 - 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Lucille Jones

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51551 ✓ 31 E 51551

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 2901 Reese St., 9-46 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucielle Jones

(a) RESIDENCE NO. 2901 Reese St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	married?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Bud Brown
(Address) 2901 Reese St

15 Filed DEC 3 - 1929 [illegible] Registrar

4128

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Puln. Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/2/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health.	ADDRESS DEC 3 - 1929

tion should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51552

1-PLACE OF DEATH

City of Baltimore: (No. Univ Hosp St. 4-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gould

(a) RESIDENCE NO. Dont Know St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Dont Know yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	C	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer) Know
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Dont Know

PARENTS

10 NAME OF FATHER Dont

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Know

12 MAIDEN NAME OF MOTHER Dont

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Know

14 Informant
(Address)

Filed DEC 3 - 1929 Registrar

4124

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Fract Rib — Contusion Chest — struck by auto in front of 60 Cary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul. Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 65 Cary

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frame M. D.

12/2, 1929 (Address) 2939 E. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Greenmount Cemetery DATE OF BURIAL 12/5/29

20 UNDERTAKER A. Jones 111 S. Eden ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JOHNS HOPKINS HOSPITAL
Department of Hygiene and Public Health
DEC 3 - 1929
Per Tim L. Hoyle

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51553

CERTIFICATE OF DEATH.

129 E 51553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1625 Mc Culloh ST. (WARD) 4-20

2-FULL NAME Harriett Thornton

(a) RESIDENCE NO. 1625 Mc Culloh ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Thornton

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John A. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Jennie Gibson

(Address) 413 Hoffman st

15 Filed DEC 3 - 1929 MPSON JONES, M. D., Registrar

By RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31 - 1929 to Nov 30 1929 that I last saw her alive on Nov - 30 - 1929 and that death occurred, on the date stated above, at 10. P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1929 (Address) 1423 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge Md — DATE OF BURIAL 12-4 1929

20 UNDERTAKER: Geo T. A. Gibson — ADDRESS 1733 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51554

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Quarantine Road ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter B. Ferguson

(a) RESIDENCE NO. Quarantine Road ST. Pennington ave
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ferguson

6 DATE OF BIRTH (month, day, and year): May 6, 1870

7 AGE: Years 59 | Months 6 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0 40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Berlin Green Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Chester
(Address) Quarantine Road

15 FILED: DEC 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Dec 1, 1929, that I last saw h. alive on Nov 30, 1929 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows: Acute Appendicitis

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home not Va

Did an operation precede death? No Date of 0

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical test

(Signed) H. Stewart, M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft Meade Va. — DATE OF BURIAL: Dec. 3 1929

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Eastlake

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

Liby

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51555

CERTIFICATE OF DEATH

90 E 51555

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 777 W Lexington St. 4-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Liby

(a) RESIDENCE NO. 777 W Lexington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Laura Liby

6 DATE OF BIRTH (month, day, and year) June 22 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	5	9 22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Second Hand Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Michael Liby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura Liby

(Address) 777 W Lexington St

Filed 12-3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/29

17 I HEREBY CERTIFY, That I attended deceased from 12/1/29 19... to 12/1/29 19..., that I last saw h... alive on 12/1/29 19..., and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

My. carditis

(duration) one hour yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Cerebral Hemorrhage

(duration) History 2 hrs yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Inadequate for over 10 yrs.

(Signed) Bernard Levy, M. D.

12/4 1929 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Atlantic City N J	Dec 4 1929
20 UNDERTAKER	ADDRESS 1532
F Vernon Kehner	Hollins

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

23 E 51556

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-00 E 51556

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Loud

(a) RESIDENCE NO. 150 E N. Broadway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 4-1929

7 AGE: Years | Months: 4 | Days: 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Loud

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mary J. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 3-1929, 19 C. HAMPSON JONES, M. D. Registrar

4126

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29-29

17 I HEREBY CERTIFY That I attended deceased from Nov. 26, 1929 to Nov. 29, 1929 that I last saw h. alive on Nov. 29, 1929 and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Dysentary

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Benj. E. Holge, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS DEC 3 - 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51557

CERTIFICATE OF DEATH

E 51557

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 E. Chase ST. 10-14 WARD)

2—FULL NAME Charles W. McCourt

(a) RESIDENCE NO. 825 E. Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. McCourt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone work

(b) General nature of industry, business, or establishment in which employed (or employer) Season

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David McCourt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Mary McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Mrs. Mary A. McCourt

(Address) 825 E. Chase St

15 Filed DEC 3 1929, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/29

17 I HEREBY CERTIFY, That I attended deceased from 11/30, 1929, to 12/1, 1929, that I last saw h alive on 11/30 1929 and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Fracture neglected

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Bernard Lowe, M. D.

12/3, 1929 (Address) 1216 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Dec 4 1929

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Greenmount Ave

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Theresa Rodowska

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51558

CERTIFICATE OF DEATH.

74-08

E 51558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S. Belnord Ave ST. 1-3 WARD)

2-FULL NAME Theresa Rodowska Radowska

(a) RESIDENCE NO. 603 S. Belnord Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 027

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Radowska

(Address) [illegible]

15 1929 C. HAMPSON JONES, M. D., Registrar.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1929, to Dec. 1, 1929, that I last saw her alive on Nov. 30, 1929, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Moran, M. D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. Dec

DATE OF BURIAL 4 1929

20 UNDERTAKER John [illegible] Weber

ADDRESS 404 Chase

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3

Cor.—10-10-29—A Co.—100 Bks.

E 51559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51559

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 26-37 Ward)

2-FULL NAME Anna Pucci

(a) RESIDENCE NO. 706 Grundy St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Pucci

6 DATE OF BIRTH (month, day, and year) May 6/1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24	0	20 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Nicholas Birscatti

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Acguanlina

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Pete Pucci
(Address) 706 Grundy St.

15 Filed 1929 C. THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 11/30/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. S. Brown, M. D.

12/3, 29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 4 1929.
20 UNDERTAKER Wendell J. Lippert	ADDRESS 300 Caton

Item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3

Spec.—2-29-28—L. F. S.—500 Bks.

E 51560 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51560

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 Aliceanna ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara V. Harry

(a) RESIDENCE NO. 1539 Aliceanna ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) December 22, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
1y	75	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Elizabeth Donohue

(Address) 707 S. Dallas St.

15 Filed Dec 3 1929 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1, 1929

17 I HEREBY CERTIFY That I attended deceased from June 1 1929 to Dec 1 1929, that I last saw her alive on Dec 1 1929 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Interstitial nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones, M. D.

Dec 2, 1929 (Address) 2938 E Oldt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Dec. 4 1929

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore & Broadway

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5156I

E 5156I

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marine Hospital ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. McLain

(a) RESIDENCE NO. 735 S. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Mclain

6 DATE OF BIRTH (month, day, and year) May 2, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54	53	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Master

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis McLain

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Reese

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Eva. C. McLain (Wife)

(Address) 735 S. Potomac St.

15 3 - 1929 19 C. HAMPSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. I 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. I, 1929, to Dec I, 1929, that I last saw him alive on Dec. I, 1929, and that death occurred, on the date stated above, at II:I5 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis coronary

(duration) yrs. mos. 2I ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Rudolph & Porter M. D.

19 (Address) Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery

DATE OF BURIAL: Dec. 4 1929

20 UNDERTAKER: Henry Sander & Sons Inc

ADDRESS: Baltimore & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51562

CERTIFICATE OF DEATH

161-001

E 51562

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1632 Wardingham St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Twin Sister Leatherbury

(a) RESIDENCE NO. 1632 Wardingham ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 10-3-29

7 AGE: Years: Twin Sister | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Leatherbury

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ada Culpepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Leatherbury

(Address) 1632 Wardingham St

15 C. HAMPSON JONES, M.D. Registrar

3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-3-29

17 I HEREBY CERTIFY, That I attended deceased from 12-[illegible], 29, to 12-3-29, that I last saw h[illegible] alive on 12-3-29, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Edema of Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? pending

(Signed) J. Hall Pleasants M. D.

1929 Address 800 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dodis, Md.

DATE OF BURIAL: 12/4 1929

20 UNDERTAKER: E. J. Fanning & Son - 1938 E. Lafayette Ave.

ADDRESS

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Selby 5103 Hopkins Pl

E 51563

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51563

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 2917 Westfield Ave (ST.) Hamilton (WARD) 43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hilton Dahle

(a) RESIDENCE NO. 2917 Westfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E Dahle

6 DATE OF BIRTH (month, day, and year) Feb 20, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Dahle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Trimlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Anna Dahle

(Address) 718 E Chase St

15 FILED 3 - 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2. 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 19 29, to Dec 2, 19 29, that I last saw him alive on Dec 2, 19 29 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Tubercle

(Signed) Hyde W. Hollen, M. D.

, 19 (Address) 5103 Hopkins Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 12/5 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Baltimore St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

122 - E 51564

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Jackson Place ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Rumbel

(a) RESIDENCE NO. 104 Jackson Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

Sex	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Rumbel

6 DATE OF BIRTH (month, day, and year) June 7, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balt City

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER George Rumbel Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mildred Rumbel

(Address) 104 Jackson Place

15 Filed 19 E. HAMPSON JONES, M. D. Registrar.

3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1. 29. to Dec 3 19 29

that I last saw h[illegible] alive on Dec 3 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What confirmed diagnosis? —

(Signed) E. H. Jones, M. D.

19 (Address) 4330 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwarz Conn

DATE OF BURIAL 12/5 1929

20 UNDERTAKER J. W. Cook

ADDRESS 1217 E Baltimore St

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 51565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

22 E 51565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3035 Remington Ave Ward 12-51)

2-FULL NAME Harriette Erich

(a) RESIDENCE NO. 3035 Remington Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Charles A. Erich, Jr.

6 DATE OF BIRTH (month, day, and year) Sept 2-1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

10 NAME OF FATHER Augustus W. Krebs

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth DeCoursey

13 BIRTHPLACE OF MOTHER (city or town) Kent Del.

(State or country) Maryland.

PARENTS

14 Informant Charles A. Erich Jr.

(Address) 3035 Remington Ave.

15 1929 C. HAMPSON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26- 1929, to Dec 2 - 1929,

that I last saw h.. alive on Dec 2 - 1929,

and that death occurred, on the date stated above, at 4:05 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Cirrhosis of Liver

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? n/a Date of

Was there an autopsy? n/a

What test confirmed diagnosis? Physical signs

(Signed) Chester Leland, M. D.

12-3-1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial 12-6 1929

20 UNDERTAKER W. E. Cook ADDRESS 1212 E Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3

Spec.—1-12-23—M&T—500 Bks.

E 51566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital 4-20 ST., WARD)

2-FULL NAME Baby Girl Morrow

(a) RESIDENCE No. 1532 John St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. 1929 E 51566

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 28 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		5 d	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Mathew Morrow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Janet Kennedy Robertson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Mathew Morrow
(Address) 1532 John St

15 Filed 1929 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-28, 1929, to 12-3, 1929, that I last saw h alive on 12-3, 1929 and that death occurred, on the date stated above, at 2.30 a m

The CAUSE OF DEATH* was as follows:

Congenital intestinal obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-2-29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem — DATE OF BURIAL Dec 4 1929

20 UNDERTAKER J M J Lichner Inc — ADDRESS N Paca

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Gesauck.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

E 51567

CERTIFICATE OF DEATH

E 51567

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 7-13 WARD)

2—FULL NAME Jennie Frank

(a) RESIDENCE NO. 1512 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed C 4 - 1929, HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 3 - 29

17 I HEREBY CERTIFY, That I attended deceased from 9-27, 1929, to 12-3, 1929, that I last saw h.. alive on 12-3, 1929 and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Tumor of left kidney - probably Sarcoma

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo. Luempfert, M. D.

12-3, 1929 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 5. 1929
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 351568

CERTIFICATE OF DEATH

+ 49 E 51568

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Walling

(a) RESIDENCE NO. 1132 E North Ave ST., WARD New Castle Dels

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE: Years 25 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Del

PARENTS

10 NAME OF FATHER Elmer Walling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 4 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1929, to Dec 3, 1929,

that I last saw h alive on Dec 3, 1929

and that death occurred, on the date stated above, at 1 50 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, right cerebral glioma, (Malignant)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Wilmington Del.

Did an operation precede death? Yes Date of Nov 26, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + Autopsy

(Signed) Clarence S Yandell, M. D.

12/3, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Castle Delaware — DATE OF BURIAL: Dec 4, 1929

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 324 E Eager St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

E 51569

228902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51569

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kenneth Wyden

(a) RESIDENCE NO. 2148 Woodbury Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 5/2/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Wyden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4 - 1929, 19 [illegible] Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Dec 3, 1929, that I last saw h[illegible] alive on Dec 3, 1929 and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Rheumatic myocarditis,
" endocarditis c
mitral stenosis and insufficiency

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J W Bickford Jr, M. D.

12/4, 1929 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aurora Anne Bonnett Co

DATE OF BURIAL Dec 7 1929

20 UNDERTAKER Chanowith Son

ADDRESS 3615 Chestnut Ave

Important: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Heiss

E 51570

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51570

CERTIFICATE OF DEATH.

+ 31

1-PLACE OF DEATH Md General Hosp

CITY OF BALTIMORE: (No. Howard + Madison ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Heisse

(a) RESIDENCE NO. Parkton, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stewartstown Pa

PARENTS

10 NAME OF FATHER Frederick Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Martha Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Record

(Address)

Filed DEC 4 - 1929 C. HAYDON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929, to Dec 3, 1929, that I last saw h alive on Dec 3, 1929, and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Peritonitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical + gross

(Signed) H L Kanfmann M. D.

12/3, 1929 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Frederick Co

DATE OF BURIAL Dec 7 1929

20 UNDERTAKER Paul Hastenstein

ADDRESS New Freedom Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Huffnagel.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51571

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 6-10 Ward)

2-FULL NAME Margaret Huffnagle

(a) RESIDENCE NO. 155 N. Luzerne St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

94-001

E 51571

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Andrew Huffnagle

6 DATE OF BIRTH (month, day, and year) Oct 17/1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	69	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Zinser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Fink

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anthony Zinser
(Address) 3321 Hartdanny St.

15 Filed DEC 4 - 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inqu. ry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ner death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Potter, M. D.

12/2/29 (Address) 502 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL Dec. 5 19 29

20 UNDERTAKER Jos. J. Herr 156 N. Luzerne — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51572

CERTIFICATE OF DEATH

43 E 51572

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6700 Old Harford Road Ward 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Elizabeth Meeke

(a) RESIDENCE NO. ~~6700 Old Harford Road~~ St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8/1860

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	69	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER John W. Meeke

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Egger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Walter R. Meeke

(Address) 6700 Old Harford Road

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Dec 1 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to Dec 1, 1929

that I last saw h[illegible] alive on Nov 1, 1929

and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Dr. W. L. Gaw, M. D.

Dec. 19 29 (Address) 3631 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — Date of Burial 12/4/29

20 UNDERTAKER Richard [illegible] 1620 — ADDRESS Ashburton

DEC - 1929

Use pencil to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51573

CERTIFICATE OF DEATH

1113 ✓

E 51573

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3717 6th St., Brooklyn 25-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn L Ardis

(a) RESIDENCE NO. 3717 6th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 23 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Fletcher F. Ardis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co Va

12 MAIDEN NAME OF MOTHER Emma Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn Md

14 Informant Mr. Fletcher F Ardis

(Address) 3717 6th street

15 Filed Dec 4 1929 H. LLOYD JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1929 to Dec 2, 1929 that I last saw h alive on Nov 30, 1929 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH was as follows: Acute Peritonitis Obstruction & gastro enteritis

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

12/3, 1929 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec 4 1929
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51574

CERTIFICATE OF DEATH

33VE 51574

1-PLACE OF DEATH

City of Baltimore: (No. 1406 Argyle Ave. St.) 14-20 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Thyson Spicer

(a) RESIDENCE NO. 1406 Argyle Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Spicer

6 DATE OF BIRTH (month, day and year): Feb. 27. 1888

7 AGE: Years 41 | Months 9 | Days 4 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Dorchesty Co
(State or country): Md

PARENTS

10 NAME OF FATHER: Grant Johnson

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Emma Travers

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md.

14 Informant: Maggie Thyson
(Address): 1406 Argyle Ave

15 Filed ..... 19 ..... H. Fenton Jones, M. D. Registrar

EC 4-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Dec 3rd 1929 (Address) Harford Co Coroner, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Grove Cemetery

DATE OF BURIAL: 12 - 4 1929

20 UNDERTAKER: Mrs Chas G Bailey

ADDRESS: 1421 Jefferson St

Use ink. Do not write in margins. Do not fold. Use no abbreviations except M. D. after physician's signature. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001 E 51575

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 W. 27th St.) (17-51 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard A. Hare

(a) RESIDENCE NO. 512 W. 27th ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel E. Hare

6 DATE OF BIRTH (month, day, and year) Nov 1-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 08

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer United Ry.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sarah E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Ethel E. Hare

(Address) 512 W. 27th St.

15 Filed DEC 4 1929, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 19 29 to Dec 3, 19 29, that I last saw h alive on Dec 3, 19 29 and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. E. Richardson M.D.

Dec 4, 19 29 (Address) 1178 W. 26 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestnut Ridge Lodge Cemetery

DATE OF BURIAL Dec 6th 19 29

20 UNDERTAKER John Merrick

ADDRESS 2008 Orleans

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51576

CERTIFICATE OF DEATH

+ 185 ✓

E 51576

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles A. Seiffert

(a) RESIDENCE NO. Ellicott City St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Emma A. (nee Uhl)

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Seiffert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ella Buehl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William A. Seiffert (Son)

(Address) 1913 Braddish Ave.

15 Filed 4-1929 C. H. Iverson JOHNS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Dec. 3, 1929

that I last saw h(??) alive on Dec 3, 1929

and that death occurred, on the date stated above, at 12 35 Am.

The CAUSE OF DEATH* was as follows:

Fracture - right femur.

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Pneumonia, hypostatic

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Ellicott City

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Laboratory Tests.

(Signed) George H. Yeager, M. D.

Dec. 3, 1929 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Ellicott City	Dec 5 19 29
20 UNDERTAKER Harry S. Starr, Ellicott City, Md.	ADDRESS

IMPORTANT. See instructions on back of certificates.

Spec.—16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51577

CERTIFICATE OF DEATH

100-001

E 51577

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 W. Curley St ST., 6-11 WARD)

2—FULL NAME Dorothy L Mince

(a) RESIDENCE NO. 2 W. Curley St ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Mince

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Davis

13 BIRTHPLACE OF MOTHER (city or town) n/a
(State or country) Virginia

14 Informant Joseph Mince

(Address) 2 W. Curley St.

15 Filed DEC 4 - 1929 19 HAMILTON JONES, II Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2/29

17

I HEREBY CERTIFY, That I attended deceased from Nov. 27, 19 29, to Dec. 2, 19 29, that I last saw her alive on Dec. 2, 19 29, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Ph. Artigiani, M. D.

, 19 (Address) 2942 Efayette L.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Hearts Cem	Dec. 4 1929
20 UNDERTAKER Lilly & Zuber Inc	ADDRESS 403 So Wolfe St.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51578

CERTIFICATE OF DEATH

100-001

E 51578

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 326 S. Chapel ST. 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William L Zimmerman

(a) RESIDENCE NO. 326 S. Chapel ST. 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Zimmerman

6 DATE OF BIRTH (month, day, and year) Oct 12-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	86	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shoemaker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katie Zimmerman

(Address) 326 S. Chapel St.

15 Filed DEC 4 - 1929, 19 ... JOHN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/29

17

I HEREBY CERTIFY, That I attended deceased from 11/30, 1929 to 12/1, 1929

that I last saw h... alive on 12/1, 1929

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis + Bronchio Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Heart failure + arteriosclerosis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N D Date of

Was there an autopsy? N O

What test confirmed diagnosis? Signs + Symptoms

(Signed) by A Anderson, M. D.

19 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	Dec 4 1929
20 UNDERTAKER	ADDRESS
Lilly + Zeiler Bros.	429 S. Wolfe St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

51579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 51579

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) ST. 90-24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Wilson

(a) RESIDENCE NO. 1929 W. Pratt ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Margaret Wilson

6 DATE OF BIRTH (month, day, and year) Aug. 6 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Andrew H. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Emma Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Wilson

(Address) 1929 W. Pratt St.

15 Filed Dec 4 1929 CLAYTON C. JONES, M. D. Registrar

Per Wild

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to December 1, 1929, that I last saw him alive on December 1, 1929 and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical examination

(Signed) Conrad Spencer Jr., M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Dec. 4 1929

20 UNDERTAKER George L. Schwatt — ADDRESS 2101 Eutaw Ave

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 51580 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 51580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Aisquith St. 10-14 WARD)

2-FULL NAME Katherine M. Wernig

(a) **RESIDENCE** No. 1202 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth 56 yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles F. Wernig

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jacob Segrist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Stelfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles F. Wernig

(Address) 1202 Aisquith St.

15 4 - 1929 Dec 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to Dec. 3, 1929, that I last saw her alive on Dec. 3, 1929, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym

(Signed) Joseph Pokorny, M. D.

Dec. 3, 1929 (Address) 2200 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Dec. 6 1929

20 UNDERTAKER Henry Hoech Sons, Inc. — ADDRESS 1301 E Eager

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51581

CERTIFICATE OF DEATH

90 51581

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Lemon ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Appel

(a) RESIDENCE NO. 1708 Lemon ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Appel

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	-	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore Ginther

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Weis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. John Appel
(Address) 628 Washington Blvd.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929 to Dec. 1, 1929, that I last saw her alive on Dec. 1, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (duration) Indefinite

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. T. Lamptell M. D.

Dec. 2 1929 (Address) 1644 S. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec. 4 1929

20 UNDERTAKER Penfield Cook

ADDRESS 1003 West Baltimore St.

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51582

CERTIFICATE OF DEATH

90 E 51582

1—PLACE OF DEATH Provident Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Smith

(a) RESIDENCE NO. 629 Gilbert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Smith

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Albert Smith

(Address) 629 Gilbert St (City)

15 Filed ....., 19.... C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1929, to Dec. 1, 1929,

that I last saw him alive on Dec. 1, 1929

and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) [signature], M.D.

12/2, 1929 (Address) 600 N Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec 4, 1929
20 UNDERTAKER Bro. Kate E. Williams	ADDRESS 322 N Schroeder St

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 E 51583

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 503 Baker St., 14-54 Ward)

2-FULL NAME Wm Jas. Brooks

(a) RESIDENCE NO. 583 Baker. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie

6 DATE OF BIRTH (month, day and year) Sept 6-1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Butts Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Brooks

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Chase

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Minnie Brooks
(Address) 503 Baker St

15 Filed ..... 19 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Rheumatism.

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) [illegible] M. D.

Dec 3, 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt [illegible] Cemetery

DATE OF BURIAL Dec 6 1929

20 UNDERTAKER Thomas E Kelson

ADDRESS 1309 Pennsylvania

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1929 C. HARRISON JONES, M. D. Registrar

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51584 — 90 ✓ — E 51584

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 17-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Howard

(a) RESIDENCE NO. 408 Myrtle Ave. ST. ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 6-10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Evelyn Stiff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14

Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

C 4-1929 H. Hanson Jones, M. D. 41287

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1929, to Nov. 27, 1929

that I last saw him alive on Nov. 27, 1929

and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Post Mortem

(Signed) Warren W. McLane, M. D.

11-30, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 4 - 1929

Important: See instructions on back of certificate.

Cor. 10-10-29 A Co. 100 Bks.

E 51585

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51585

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2300 Edmondson Ave., 15th Ward)

2-FULL NAME Ralph T Wheatley.

(a) RESIDENCE NO. 1734 Fulburton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Le Compte Wheatley

6 DATE OF BIRTH (month, day, and year) 6-2-1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER T. T. Wheatley

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Blanche Wheatley
(Address) 1734 Fulburton St.

15 Filed DEC 4 - 1929 19 C. HAMPSON JONES, Registrar

By Nate

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Dec 3rd 1929 H. Leslie Haines M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vienna - Md.

DATE OF BURIAL Dec 6 1929

20 UNDERTAKER Mr. Mrs. John W. Teufel & Son

ADDRESS 501 W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51586

CERTIFICATE OF DEATH

101-001

E 51586

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 N. Charles St ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robina Wallace Reid

(a) RESIDENCE NO. 609 N. Charles St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26th 1876

7 AGE	53 Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) St Louis (State or country) Missouri

PARENTS

10 NAME OF FATHER J. T. S. Reid

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Reid

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Va

14 Informant W. W. Abell

(Address) 609 N. Charles St

15 Filed DEC 4 1929 19... HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25th 1929, to Dec. 3rd 1929, that I last saw h[er] alive on Dec. 3rd 1929, and that death occurred, on the date stated above, at 3:57 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ...yrs. ...mos. 8 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination & Symptoms

(Signed) Wm N. Dabney, M. D.

Dec 4th, 1929 (Address) Wheaton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL 12-4 1929

20 UNDERTAKER Henry W. Jenkins & Son Co

ADDRESS Richard McCulloh

Spec.—2-29-28—L. F. S.—500 Blks.

E 51587

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. T. Hooper

E 51587 1929

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 Wilkens Ave ST.) (WARD) 27-001

REGISTERED NO. 1870

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Hooper

(a) RESIDENCE NO. 2122 Wilkens ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Hooper

6 DATE OF BIRTH (month, day, and year) March 17: 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. J. Hooper

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Aspiller

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Emma Hooper
(Address) 2122 Wilkens Ave

15 Filed ... 19 ... Registrar

C 4 - 1929 HARRISON-JONES CO.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2/1929

17

I HEREBY CERTIFY, That I attended deceased from 29 Nov, 1929, to 2 Dec, 1929, that I last saw h[illegible] alive on 2 Dec 1929 and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam & Autopsy

(Signed) J. Vance Hooper, M. D.

, 19 (Address) 2520 Folkes Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 4th 1929
UNDERTAKER	ADDRESS
E. B. Wappert	1850 W. Balto St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51588

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2522 W. Chatt ST. 20-69 WARD)

2—FULL NAME Harry A Engel

(a) RESIDENCE NO. 2522 W Chatt ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 5 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE of Margaret B Engel

6 DATE OF BIRTH (month, day, and year) June 17 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. P.O. 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John C. Engel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Mundel

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Margaret B Engel
(Address) 2522 W Chatt St

15 Filed DEC 4 - 1929 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3/29

17 I HEREBY CERTIFY, That I attended deceased from 10 Nov, 1929, to 3 Dec, 1929, that I last saw h.. alive on 3 Dec, 1929, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Miliary of Lungs.

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N.K.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) Francis Hagan, M. D.

3 Dec, 1929 (Address) 2565 Frankln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Park Cemetery — DATE OF BURIAL Dec 6th 1929

UNDERTAKER F B Reichert 1850 — ADDRESS W Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

59-003 E 51589

1—PLACE OF DEATH President Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Thomas

(a) RESIDENCE NO. 1700 Madison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col'd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1929.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. H. Thomas.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Cooper

13 BIRTHPLACE OF MOTHER (city or town) Laurel
(State or country) Del.

14 Informant Mrs Catherine Thomas.

(Address) 1700 Madison Ave.

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Dec. 2, 1929, that I last saw h.... alive on Dec. 2, 1929, and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis

2 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

2 wks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of 11/28/29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Bernard Sarin, M. D.

12/3 1929 (Address) President Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Dec 5 19 29
20 UNDERTAKER	ADDRESS
Samuel Weeks	1129 E. Fayette St.

A 1929 C HARRY JONES, M.D.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51590 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51590

1—PLACE OF DEATH Park Heights Ave + Slem Pike REGISTERED NO.

CITY OF BALTIMORE. (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Morton

(a) RESIDENCE NO. 2113 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Morton

6 DATE OF BIRTH (month, day, and year): March 22-1881

7 AGE — Years: 48 Months: 8 Days: 9 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Talbot Co. Md

PARENTS

10 NAME OF FATHER: James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Margaret Brooks

(Address) 116 W. 25th St.

15 Filed DEC 4 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1-29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1929 to Nov. 1, 1929, that I last saw h alive on Nov. 2, 1929, and that death occurred on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Handley, M. D.

11/2/1929 (Address) 1230 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md DATE OF BURIAL: Dec 5 1929

20 UNDERTAKER: David J. Hendley ADDRESS 518 N Bond St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51591

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51591

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Mercy Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 200 N Calvert ST., 19-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis J. Fernsner

(a) RESIDENCE NO. 408 N Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis J. Fernsner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mother c. Boundy
(Address) 80 Keyser Blda.

15 Filed ....., 19 HERBERT S. JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1929, to December 3, 1929, that I last saw him alive on December 2, 1929, and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(31 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (Apoplexy)

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Chemistry

(Signed) Sandra Weichardt, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec. 5, 1929

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl. — ADDRESS

W. B. Mitchell

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51592

CERTIFICATE OF DEATH

129

E 51592

1—PLACE OF DEATH

REGISTERED NO.

27-46

CITY OF BALTIMORE: (No. 706 Gladstone Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Frederick Sutton

(a) RESIDENCE NO. 706 Gladstone Ave. ST., WARD
(Usual place of abode) Life
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. Porter

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Robt. M. Sutton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Laura Deggs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wash., D. C.

14 Informant Mrs. Eliz. Porter Sutton
(Address) 706 Gladstone Ave.

15 Filed C. HAMPSON JONES M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Dec 2nd, 1929, that I last saw him alive on Dec 2nd, 1929 and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Hypertension.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) H. A. Bladard, M. D.

Dec 3rd 19 (Address) 1300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec. 5, 1929

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

M. R. Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51593

CERTIFICATE OF DEATH

113 E 51593

REGISTERED NO.

1—PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard + Green ST., 18-29 WARD)

2—FULL NAME Clara Howard

(a) RESIDENCE NO. 38 S. Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28th 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edwin Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mamie Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va.

14 Informant Mrs Mamie Howard

(Address) 38 S Carlton St

15 Filed 4 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Dec 4, 1929, that I last saw her alive on Dec 4, 1929, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Marasmus

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter B. Johnson, M. D.

Dec, 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. — DATE OF BURIAL Dec 5th, 1929

20 UNDERTAKER John J Cowan Son — ADDRESS 901 Baltimore St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 51594 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51594

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 402 Edgewood St. 20-10 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Piquett

(a) Residence No. 402 Edgewood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~ Married, ~~Widowed, or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Francis E. Piquett

6-DATE OF BIRTH (month, day and year) July 14 1886

7-AGE. 43 yrs. 4 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm Tate

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Emma Holley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

11- (Informant) Francis E. Piquett

(Address) 402 Edgewood St

13- Filed 4-1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3rd-29

17- I HEREBY CERTIFY, That I attended deceased from May 11 1929 to Dec. 3 1929 that I last saw h[illegible] alive on Dec. 3 1929 and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Uremia

Chr. Bright's Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? [illegible] Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry E. Wilson M.D.

, 19 (Address) 3 N. Budde st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 7th 1929

20-UNDERTAKER, Theda Holzaus & Son — ADDRESS 703 S Hanover St

instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51595

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 12-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles M. Coleman.

(a) RESIDENCE NO. 1210 Hanover St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce dealer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James P. Coleman.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma Johnson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Michigan.

14 Informant Howard A. Coleman. (brother)
(Address) 1210 Hanover St.

15 [illegible] 1929 G. HAMPSON JONES, II, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Broncho-pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 82 E. Cross St.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt M. D.
12/4, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.
DATE OF BURIAL Dec. 5 1929

20 UNDERTAKER Margaret S. Flynn
ADDRESS 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51596

CERTIFICATE OF DEATH

168

E 51596

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. City Jail St., 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Holland

(a) RESIDENCE NO. ? St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed DEC 5 - 1929 C. HAMPSON JONES, M. D., Registrar

4129

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 / 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Acute Lobar

Influenza Edema

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. T. Linn Lyman M. D.

DEC 4 19 29 (Address) 1633 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health

DEC 4 1929

THE MORNING SUN

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51597

CERTIFICATE OF DEATH

70 ✓ E 51597

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 430 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Palmer

(a) RESIDENCE NO. Found On Gross St near Loudon St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 35 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Res death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Fracture of Skull
Cause unknown
by Motor Car

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS

DEC 4 - 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 1929 THOMPSON-JOHN'S, INC. THE MONROE

Cor.—10-10-29—A Co.—100 Bks.

E 51598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51598

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 312 High St. 3-5 Ward)

2-FULL NAME John Ackerman

(a) RESIDENCE NO. None St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 60 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical History

(Signed) G C Hamman M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health — ADDRESS DEC 4 - 1929

DEC 5 - 1929

4131 THE MORGUE

C. HAMPSON JONES, M. D.

Registrar

IMPORTANT: Fill out this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51599

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51599

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: (No. 29 Caroline St., 3-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Horsey

(a) RESIDENCE NO. 29 S Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19.... Registrar

4132

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Hy Stories

(Signed) G C Hadley, M. D.

19 (Address) 453 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

DEC 4 - 1929

DEC 5 - 1929 H. LEWIS JONES, M.D.

Commissioner of Health

THE MONUMENTAL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90V E 51600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 N Calvert ST. 11-19 WARD)

2—FULL NAME Mary Emory Markoe.

(a) RESIDENCE NO. 813 N. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S Markoe

6 DATE OF BIRTH (month, day, and year) March 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Emory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John S. Markoe

(Address) 1313 N. Calvert St.

15 Filed 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-29

17 I HEREBY CERTIFY, That I attended deceased from 1928, 19, to 12-3, 1929, that I last saw h E R alive on 12-3, 19 29, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

CONTRIBUTORY (Secondary) (duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Jones, M. D.

19 (Address) 1129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St James Cem My Ladys Manor

20 UNDERTAKER Henry H. Jenkins Sons

DATE OF BURIAL Dec 5 1929

ADDRESS McCuaglo Forestville Md.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51601

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 51601

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2313 Ellamont ST. 15-6T WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Walter Starkloff

(a) RESIDENCE NO. 2313 Ellamont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): June 14, 1888

7 AGE — Years: 41 | Months: 5 | Days: 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: E. L. Stevens 26

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm B. Starkloff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Steke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs Celeste D. Starkloff

(Address) 2313 Ellamont St

15 Filed Dec 5 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Dec 3, 1929, that I last saw him alive on Dec 3, 1929, and that death occurred, on the date stated above, at 4.25 p.m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? (duration) about 3 yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S Willett M. D.

Dec 4, 1929 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: Dec 5 1929

20 UNDERTAKER: Wm Tuckwell Sons

ADDRESS: North Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51602

CERTIFICATE OF DEATH

E 51602

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Huron St. Ward) REGISTERED NO. 25332

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sedonia Savoy Williams

(a) RESIDENCE NO. 2600 Huron St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brets Md

PARENTS

10 NAME OF FATHER: Thos Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Julia Nugent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Chas F. Parker

(Address) 2600 Huron St

15 Filed DEC 5 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/2/29

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 19 29, to 12/2, 19 29, that I last saw h[illegible] alive on 12/1/29, 19, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

a Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/4, 19 29 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 12-5 1929

20 UNDERTAKER: John H Toadvine — ADDRESS 1027 Lombard

Spec.—1-10-21 M&T 1500 Blks.

E 51603 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9a E 51603

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Corbin am Furgus 2-76 ST. WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jones

(a) RESIDENCE No. Corbin am Furgus ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry Kear

(Address) Fairfield Md

15 Filed DEC 5 1929 C. [illegible] JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3- 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/25/29, 19..., to 12/3, 1929.

that I last saw h[illegible] alive on 12/2 — 1929.

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Chronic Asthma

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Leibaugh M. D.

19 (Address) 1340 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL Dec 5 1929

20 UNDERTAKER J. L. Brown & Son

ADDRESS 1081 Mondy

TION is very important. See instructions on back of certificates.

11.20

Cor.—10-10-29—A Co.—100 Bks.

Merel

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51604

CERTIFICATE OF DEATH

129 E 51604

1-PLACE OF DEATH

City of Baltimore: (No. 1821 Hennenan Ave St., 7-13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Franklin Mercl

(a) RESIDENCE NO. 1011 N. Wolfe St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Mercl

6 DATE OF BIRTH (month, day, and year) Sept 12-1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	52	2	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Former 67
(b) General nature of industry, business, or establishment in which employed (or employer) Paper Hanger
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Mercl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Theresa kkkkkk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Mary Loyd
(Address) 2022 E. Biddle St

Filed 12-5-1929 19.. [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/3/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL Dec 5 1929

20 UNDERTAKER [illegible] & Sons — ADDRESS 1906 Baltimore

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

E 51605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 51605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 Division ST., 14-20 WARD)

2-FULL NAME Annie Angeline Jackson

(a) RESIDENCE NO. 1536 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of Samuel Jackson

6 DATE OF BIRTH (month, day, and year) May 14 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Co Va.

PARENTS

10 NAME OF FATHER Isaac Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lucinda Plummer

(Address) 913 Penna Ave

15 Filed DEC 5 - 1929 C. HUNTON JONES, M. D. Registrar

No. 1101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to Dec 2, 1929, that I last saw her alive on Dec 2, 1929, and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum test

(Signed) C. William Frey, M. D.

12/3, 1929 (Address) 1720 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL? Mt Zion Cem DATE OF BURIAL 12-5 1929

20 UNDERTAKER David Taylor ADDRESS 916 Pa ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

51606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51606

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Mt Holly ST. 1565 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence D. Heaton,

(a) RESIDENCE NO. 2809 Mt Holly ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Heaton,

6 DATE OF BIRTH (month, day, and year) Dec. 26. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City. N. Y.

PARENTS

10 NAME OF FATHER William Heaton,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Maria Warford.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Saylem N. Y.

14

Informant Mrs. Wm. J. Miller,

(Address) 2809 Mt Holly St.

15

Filed 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Dec 4, 1929, that I last saw h in alive on Dec 3, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary & General Adema,

CONTRIBUTORY (Secondary) Circulatory Collapse (Senile) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

over

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Townsend, M. D.

4, 1929 (Address) 2806 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md — DATE OF BURIAL 19

20 UNDERTAKER Robert S Little — ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Keller.

E 51607

CERTIFICATE OF DEATH

E 51607

1—PLACE OF DEATH TERROLL Place

REGISTERED NO. 31

CITY OF BALTIMORE: (No. 1729 Terrell Place ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Stecker

(a) RESIDENCE NO. 1729 Terrell Place ST., 9 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If ~~married, widowed, or~~ divorced
HUSBAND of
(or) WIFE of ~~of~~ single

6 DATE OF BIRTH (month, day, and year) May 19-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	54	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) B.C. Wurm Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Fredrick Stecker

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Magdelina Gaul

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant Louise Stecker
(Address) 1729 Terrell Place

15 Filed ..... 19.. C. HARRISON JONES, M. D. Registrar

C 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2. 29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929, to Dec 2, 1929, that I last saw h. alive on Dec 1, 19 29 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 4 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No. Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) Geo. F. [illegible], M. D.

12. 3. 1929 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. — DATE OF BURIAL Dec 5 1929

20 UNDERTAKER Kilby Zeiler Co. — ADDRESS 453 E. Monument

Spec.—12-9-25—A Co.—200 Blks.

E 51608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 51608

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 234 N Carey St. 19-26 (Ward)

2-FULL NAME Infant of Mr & Mrs John S Brown

(a) RESIDENCE NO. 234 N Carey St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 3-1929.

7 AGE — Years: — Months: — Days: — IF LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John S Brown

11 BIRTHPLACE OF FATHER (city or town) Balto Co.

(State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Madia C.

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Mrs M. L. Brown

(Address) 234 N. Carey St.

15 Filed _____, 19____ _____ Registrar

DEC 5 - 1929

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) Dec 3 19 29.

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 19 29, to Dec 3, 19 29, that I last saw h[illegible] alive on Dec 3, 19 29, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. Campbell M. D.

Dec 3, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Kehrer State Board

Date of Burial: ____ 19____

20 UNDERTAKER: Commissioner Health

ADDRESS

DEC 4 - 1929

Spec.—12-9 25—A Co.—200 Bks.

E 51609

HEALTH DEPARTMENT—CITY OF BALTIMORE

V61-001

E 51609

CERTIFICATE OF DEATH ~~STILL BIRTH~~ No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE (No. 234 N. Carey St. 19-26 Ward)

2-FULL NAME Infant of Mr. & Mrs. John N. Brown

(a) RESIDENCE NO. 234 N. Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3- 1929.

7 AGE — Years — Months — Days — IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John N. Brown

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Madick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs M. E. Brown (Address) 234 N. Carey St.

15 Filed ... 19 ... Registrar

DEC 3 - 1929 4133

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 19 29.

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to Dec 23, 1929 that I last saw h.. alive on Dec 23, 1929 and that death occurred, on the date stated above, at 5-00 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Ophthalmia

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Sloan Campbell M. D.

Dec 3, 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Robert Slater Board — Date of Burial 19

20 UNDERTAKER — ADDRESS

DEC 4 - 1929

Cor.—10-10-29—A Co.—100 Bks.

Kennedy

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51610

45 E 51610

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 20-69 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. E. Kennedy

(a) RESIDENCE NO. 2311 Lorretta Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13/1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46	11	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R 631
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael J. Ken[illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Margaret Kennedy (sister)
(Address) 2311 Lorretta Ave

15 Filed DEC 5 - 1929 By C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to HIS death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid (Lower End)

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 4/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. [illegible], M. D.

12/4/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 12/7 1929

20 UNDERTAKER J. C. Brannigan — ADDRESS 1136 Poplar Grove St

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Cause of death in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

Dorsey

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51611 ✓E 51611

CERTIFICATE OF DEATH

167-001

27-44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2705 Halcyon Ave St., Ward)

2-FULL NAME Ruth H dorsey

(a) RESIDENCE NO. 2705 Halcyon Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. L. Dorsey

6 DATE OF BIRTH (month, day, and year) Apr 1/1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Henry J. Brockman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Caroline F.Lawrence

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Robt. L. Dorsey
(Address) 2705 Halcyon Ave

15 Filed 19 C. Harry Jones, M. D., Registrar

Dec 5 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphyxiation.
(Suicide)(Gas Range in Kitchen)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Encephalitis-0 none A-0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/3/30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec 5 1929

20 UNDERTAKER: H M Rouleon

ADDRESS: 2228 N Mtk

Be BRIEF in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51612

CERTIFICATE OF DEATH

101-001

101 E 51612

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2307 Tioga Park Way Street 45-58 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriam Lipnick

(a) RESIDENCE NO. 2307 Tioga Park Way Street Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 64 Months — Days — IF LESS than 1 da. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Wolf Wolff

11 BIRTHPLACE OF FATHER (City or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER: Rosa Hesinger

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: H. Lipnick

(Address) 2307 Tioga Pl.

Filed Dec 5 1929 C. HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 25th 1929, to Dec 4th 1929, that I last saw h[er] alive on Dec 4th 1929, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Emphysema Complete

Terminal Pneumonia ?

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Extremities

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical finding, Symptoms

(Signed) Joseph Lichter M. D.

Dec 5th 1929 (Address) 320 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial 12/5 1929

20 UNDERTAKER: Sol Levinson Bro — ADDRESS 1127 E Baltimore St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Moses Barzune

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51613

91-002 E 51613

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St., 6-10 Ward)

2-FULL NAME Moses Barzune

(a) RESIDENCE NO. 210 N. Collington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Barzune

6 DATE OF BIRTH (month, day, and year) Aug 9 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74 75	3	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Butcher 013
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Joe Barzune

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Musin Barzune
(Address) 210 N. Collington Ave

15 Filed 23 19 C. HUMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac failure - Pulm Oedema

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility - arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Hamilton, M. D.

12/5/29, 19 (Address) 503 E. Monument Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

20 UNDERTAKER Sol Levinson & Bro

DATE OF BURIAL 11/5 19 29

ADDRESS 1127 E Balto St

Be sure that all items are properly filled. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51614

E 51614

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3550 Poole St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie M. Rogers

(a) RESIDENCE NO. 3550 Poole St. ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank M. Rogers

6 DATE OF BIRTH (month, day, and year) July 11-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza J. Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John R. Rogers

(Address) 3559 Poole St.

15 Filed DEC 5 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Dec 3rd, 1929, that I last saw her alive on Dec 3rd, 1929, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Edema (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms, Clinical findings

(Signed) B. A. Fussell, M. D.

12/5/1929 (Address) 3611 Falls Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Dec. 6- 1929.
20 UNDERTAKER	ADDRESS
Horace H. Burgee	3631 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 51615

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 51615

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 26-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Abel

(a) RESIDENCE NO. None ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 4135 • Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from 14, 19, to Dec. 1, 19 29,

that I last saw him alive on Dec. 1, 19 29

and that death occurred, on the date stated above, at 3:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Toxic

(duration) over 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Aut. Op.

(Signed) Harris M. McLean, M. D.

12-1, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

DEC 3 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 51616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 51616

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Dorsey

(a) RESIDENCE NO. 536 N. Eden ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary F. Milburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed DEC 5 1929 19 4138 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 19 29, to Nov. 29, 19 29, that I last saw him alive on Nov. 29, 19 29 and that death occurred, on the date stated above, at 5:20 A. M.

The CAUSE OF DEATH* was as follows:

~~Epidural Abscess~~

Thyocarditis, Chronic Acute

Phlebitis, Chronic Acute

(duration) 20 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Aneurysm of Abdominal Aorta (duration) 5 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Aut. & C. Lab

(Signed) Warren H. McLean, M. D.

12-1, 19 29 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 5 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51617

CERTIFICATE OF DEATH

E 51617

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 74-001

CITY OF BALTIMORE: (No. ..... ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Skinner

(a) RESIDENCE NO. 1524 N. Stricker ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed DEC 5 1929 C. Lincoln Jones, M. D. Registrar
5-1929 413

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-29

17 I HEREBY CERTIFY, That I attended deceased from 5-20-15, 19..., to 12-3-29, 19..., that I last saw her alive on 12-3-29, 19..., and that death occurred, on the date stated above, at 8:35 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

..... (duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Hypertension

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.C. Lab

(Signed) Marion W. McLean, M. D.

12-4, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL
DEPARTMENT OF HEALTH
DEC 5 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51618 E 51618

CERTIFICATE OF DEATH

54

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 25-17

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christ Schuck

(a) RESIDENCE NO. Cherry St., Curtis Bay ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Schuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Nettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of

(Address Balto. City Hospitals

15 Filed 5 1929 4136 C. HUNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929 to Dec. 1, 1929, that I last saw him alive on Dec. 1, 1929 and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) ..... yrs. over mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. over mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ref. P.C.

(Signed) Marvin M. Steam, M. D.

12-1, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS DEC 3 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 51619

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51619

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 823 Hollins ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ANNE SADAVSKENE

(a) RESIDENCE NO. 823 Hollins ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? 17 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1888

7 AGE	41	Years —	Months	— Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania
(State or country)

PARENTS

10 NAME OF FATHER M. Kulevicus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER Elezabeth Ruseckas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

14
Informant Joseph Kulevicus
(Address) 823 Hollins Street

15
Filed ..., 19... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4/29

17
I HEREBY CERTIFY, That I attended deceased from 11/21, 1929, to 12/4/, 1929,
that I last saw h[illegible] alive on 12/4/, 1929
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:

Pul. Phthisis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard J. Ferry, M. D.

12/4, 1929 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 7. 1929

20 UNDERTAKER John Grebliauckas — ADDRESS 423 S Paca St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51620

CERTIFICATE OF DEATH.

E 51620

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Mad Ave WARD 20)

2-FULL NAME Bettie Scott

(a) RESIDENCE NO. 1719 Madison WARD Insane

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 21 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonas Langford

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant ... (Address) 1719 Madison Ave

Filed DEC 5 1929 WILLIAM H. LEMMON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/1 1929, to 11/27 1929, that I last saw h... alive on 11/26 1929, and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows: Epileptic seizure Disease

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Do

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Les Ellis M. D.

(Address) 624 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Woodlawn

DATE OF BURIAL Dec 7, 1929

20 UNDERTAKER Wm. R. A. Elliott

ADDRESS 720 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51621

CERTIFICATE OF DEATH

12-29 E 51621

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1214 Division ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arise Jones

(a) RESIDENCE NO. 1713 Baker ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arise Jones

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Arise Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Antigua

14 Informant Clarence Smith

(Address) 1713 Baker St.

15 Filed DEC 5 1929, 19... JAMES H. COLE M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Dec 2, 1929, that I last saw h... alive on Dec 2, 1929 and that death occurred, on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio-vascular-renal disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) about yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Laboratory

(Signed) W. Jackson M. D.

12/2, 1929 (Address) 600 Mallory St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	12/5/29 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS Laurel

Spec.—1-12-23—M&T—500 Bks.

E 51622

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves (ST.) 25-12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Patrick J. Kenny

(a) RESIDENCE NO. Lansdowne, Md (ST.) (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE: Years 51; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Catholic Priest

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Massaw, Md

PARENTS

10 NAME OF FATHER: Simon Kenny

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland - Co. Wexford

12 MAIDEN NAME OF MOTHER: Margret Cavanagh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland - Co. Wicklow

14 Informant: Thomas J. Kenny (Address) Cumberland Md

15 Filed ... 19 ... H. M. JONES, M. D. Registrar

DEC 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6th —, 1929, to Dec. 4th —, 1929, that I last saw him alive on Dec. 4th, 1929, and that death occurred, on the date stated above, at one p m

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Paul Owen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Michaels Cem Frostburg, Md — DATE OF BURIAL: Dec 9th 1929

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 901 Baltimore St.

FROM is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51623

CERTIFICATE OF DEATH

× 114 E 51623

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. Howard + Madison St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Blizzard

(a) RESIDENCE NO. Finksburg Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1st, 1847

7 AGE: Years 82 Months 4 Days 13 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Finksburg (State or country) Md

PARENTS

10 NAME OF FATHER Morris Blizzard

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cuffles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hdqrs. Record (Address)

15 Filed DEC 3 - 1929 16 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 1929, to Dec 5 1929, that I last saw h.. alive on Dec 5 1929, and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. H. Kretschmeier, M. D.

Dec 5 1929 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Hades — Date of Burial Dec 8 1929

20 UNDERTAKER H. Barnhardt & Son — ADDRESS Westminster Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51624

CERTIFICATE OF DEATH.

49 E 51624

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Louis Berger

(a) RESIDENCE NO. Sinai Hospital ST., 2009 E. Lombard St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Selma Berger

6 DATE OF BIRTH (month, day, and year): December

7 AGE: 69 yrs

Years	Months	Days	If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10 NAME OF FATHER: Harry Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fannie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia.

14 Informant (Address): J. Lewis 1432 E Balto

15 Filed 5-1928 19 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-4 1928

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1928, to Dec. 4, 1928, that I last saw h[illegible] alive on December 4, 1928, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinomona of Pancreas

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Samuel J. Kaufman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int. Carmel — DATE OF BURIAL: 12-5 19 28

20 UNDERTAKER: Jack Lewis, 1432 E Balto — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51625

CERTIFICATE OF DEATH

74-001 E 51625

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 708 E. 21st St. ST., 9-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Susan Jackson

(a) RESIDENCE NO. 708 E. 21st. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Jackson

6 DATE OF BIRTH (month, day, and year) Mar 22, 1845

7 AGE	Years	Months	Days 11	If LESS than 1 day, hrs. or min.
84		8 mos	14	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Perdue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Jackson
(Address) 708 E. 21st St.

15 Filed [illegible] 19 THOMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3, 29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1928, to Dec. 3, 1929, that I last saw h[illegible] alive on Dec. 3, 1929 and that death occurred, on the date stated above, at 7:35 P.m.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis & hyper. tension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin D Jarrett M. D.

19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Christ Church Cemetery DATE OF BURIAL Dec 6 19 29

20 UNDERTAKER [illegible] ADDRESS 1324 [illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

E 51626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51626

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Park Side Drive ST., 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Schoenleins

(a) RESIDENCE NO. 3006 Park Side Drive ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenz Schoenlein

6 DATE OF BIRTH (month, day, and year) Nov. 26/1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Oldenwurtel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Miss Elizabeth Schoenleins

(Address) 3006 Park Side Drive

15 Filed DEC 3 1929 WILLIAM H. JONES, M. D. Registrar

C 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924, to Dec 3rd, 1929, that I last saw her alive on Dec 3rd, 1929, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

*(Signed) Brucen F. Grimes, M. D.

Dec 4, 1929 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 6 1929

20 UNDERTAKER Jos. J. Kerr — ADDRESS 156 N. Luzerne Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51627 ✓ E 51627

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 223 N. Lakewood St. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy P. Dentz

(a) RESIDENCE NO. 223 N. Lakewood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Dentz

6 DATE OF BIRTH (month, day, and year) June 10 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
63	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster (State or country) Pa.

PARENTS

10 NAME OF FATHER Edward Breckel

11 BIRTHPLACE OF FATHER (city or town) Lancaster (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catharine Rice

13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)

14 Informant Mr. Henry Dentz

(Address) 223 N. Lakewood

15 Filed Dec 5 - 1929, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 3 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 8th, 1929, to Dec. 3d, 1929, that I last saw her alive on Dec. 3d, 1929, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Acute Phlebitis of legs
Cardio-vascular-renal disease & Hypertension
(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Embolism and Thrombosis of left lung (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Chris Sellentag M. D.

12/4, 1929 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec. 7 1929

20 UNDERTAKER J. J. Derr — ADDRESS 150 N. Luzerne

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51628

CERTIFICATE OF DEATH

45 E 51628

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 619 N Spring ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Gardner

(a) RESIDENCE NO. 619 N Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

6a If married, widowed, or divorced (or) WIFE of John Gardner

6 DATE OF BIRTH (month, day, and year) approx 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Charity Jinnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Chas Johnson (dau)

(Address) 619 N Spring St.

15 Filed Dec 6 1929 H. L. JONES, M. D. Registrar

C 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Dec 2, 1929, that I last saw h[illegible] alive on Dec 1, 1929 and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Malignancy Rectum
(Probably Carcinoma)
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis and Hypertension Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. T. Young, M. D.

12/4, 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Dec 6 1929

20 UNDERTAKER Wm J. D. Lockes

ADDRESS 1302 Gilford

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51629
1-PLACE OF DEATH

198

E 51629
REGISTERED NO.

City of Baltimore: (No. Hopkins Hospital St. 58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Tarleton

(a) RESIDENCE NO. 1143 McElderry St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About 30				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Police Records
(Address)

15 Filed ....., 19.... LUTHER JONES, M. D.
Registrar

DEC 5 - 1929
THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(over)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Stab Wounds rec'd Nov 12

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes - Dr Medela

What test confirmed diagnosis?

(Signed) Jos E Allen, M. D.

12/4/29 (Address) 50 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS DEC 6 - 1929

IMPORTANT—Fill out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51630
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1031 Penna Ave St. 7-24 Ward)

2-FULL NAME Norman Ralf

(a) RESIDENCE NO. Unknown. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N. W. Local Police Station
(Address)

Filed DEC 5 - 1929, 19 H. LAWSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Hemorrhage due to pistol wound of brain
Suddenness (duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Penna Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. Blood Smith M. D.
Nov 26th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — PUBLIC CEMETERY

DATE OF BURIAL 19

UNDERTAKER

ADDRESS

Commissioner Health

DEC 5 - 1929

Form C. H. 8

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

198 E 51631

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. In front of 780 S. Charles St. St., 22-31 Ward)

2-FULL NAME Joseph Reed. (C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	80	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

Filed DEC 5 - 1929 LAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to a stab wound of the neck, involving Carotid Artery and Internal Jugular Vein. Homicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry.

(Signed) Otto Stoll & Leonhardt, M. D.

12/8, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER PUBLIC CEMETERY

ADDRESS

THE MORGUE

DEC 5 - 1929

Commissioner Health

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51632

CERTIFICATE OF DEATH.

49 E 51632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 Highland Drive ST., Govan 29-7-18 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Adelaide Schad

(a) RESIDENCE NO. 706 Highland Drive ST., Govan WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. X ds. How long in U. S., if of foreign birth? 72 yrs. 2 mos. 4 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 29 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None None

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant Edwards Hall
(Address) 706 Highland Drive

15

DEC 5 - 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1929

17

I HEREBY CERTIFY, That I attended deceased from April, 1925, to Dec 3, 1929, that I last saw h alive on Dec 3rd, 1929, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 3 yrs. 4 mos 6 ds.

CONTRIBUTORY (Secondary) General debility nurses

(duration) 8 yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? growth + distin

(Signed) Dr JE Benson M. D.

Dec 4. 1929 (Address) 6010 York Road Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Dec 6 1929

20 UNDERTAKER Jos Jos Lambert & Son

ADDRESS 2178 Penn

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51633

CERTIFICATE OF DEATH

3/ E 51633

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent Genovese

(a) RESIDENCE NO. 1008 Granby st. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 00

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Genovese

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Italy

12 MAIDEN NAME OF MOTHER Venera Simlordi

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Italy

14 Informant Hospital Records
(Address)

15 Filed ..... 19 C. HEMPSON JONES, M. D.
-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1929, to Dec. 3, 1929, that I last saw h im alive on Dec. 3, 1929 and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

12-3-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 7 1929.
20 UNDERTAKER Kendall & Hespel	ADDRESS 3308 Elm

Spec.—2-29-28—L. F. S.—500 Blks.

E 51634

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51634

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE, No. South Baltimore General Hospital

REGISTERED NO. 118-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Jennie Dressel

(a) RESIDENCE NO. 1120 Carroll ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Fred Dressel

6 DATE OF BIRTH (month, day, and year) Sept 21 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Fred Bedeman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER M. Bruns

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant H. Dressel

(Address) 1120 Carroll St

15 Filed 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4-29

17 I HEREBY CERTIFY, That I attended deceased from 11-16, 1929, to 12-4, 1929, that I last saw h alive on 12-4 1929 and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

Intestinal obstruction (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/18/29

Was there an autopsy? Yes

What tests confirmed diagnosis? Surgical Organ

(Signed) Joseph D. Laukaitis, M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 12/7/29

UNDERTAKER Lee Leimbach Co

ADDRESS 5711 York Rd

Spec.—2-29-28—L. F. S.—500 Bks.

E 51635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 51635

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Stenett St., 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Vanskoln

(a) RESIDENCE NO. 1121 Stenett ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Katherine Vanskoln

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	49		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Can Lavery

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt Vanskoln

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Kat Kuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Katherine Vanskoln

(Address) 1134 Cleveland St

15 Filed 1929 C. H. THOMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4/29

17

I HEREBY CERTIFY, That I attended deceased from 12/21/29, 19..., to 12/4/29, 19...,

that I last saw h... alive on 12/4/29, 19...

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) History yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Bernard J. Lavery, M. D.

12/5/, 1929 (Address) 9 W Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 12/7/29

20 UNDERTAKER Geo Kemberth & Son

ADDRESS Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

E 51636 HEALTH DEPARTMENT—CITY OF BALTIMORE 74 0E 51636

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 26-39

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Foster

(a) RESIDENCE NO. 3415 Esther Place ST., ... WARD
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 11 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68?		6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can-maker

(b) General nature of industry, business, or establishment In which employed (or employer) ? 086

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Records (Address)

Filed 5 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-29

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 1928, to 12-3, 1929, that I last saw h.... alive on 12-3, 1929 and that death occurred, on the date stated above, at 945 P m.

The CAUSE OF DEATH* was as follows:

Pneumohaemia Cerebrum

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

..... (duration) ..... yrs. 18 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C. Lab

(Signed) Marion Ly McLean, M. D.

12-4, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL Dec. 6 1929

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Broadway

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51637

CERTIFICATE OF DEATH

129 E 51637

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Md. General Hospital St. 1-45 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carter

(a) RESIDENCE NO. 1704 Victory Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine F. Carter

6 DATE OF BIRTH (month, day, and year) March 14, 1890

7 AGE	Years	Months	Days
	39	8	20

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic do

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER James Carter

11 BIRTHPLACE OF FATHER (City or town) (State or country) Cecil Co. Maryland

12 MAIDEN NAME OF MOTHER Mary Spellman

13 BIRTHPLACE OF MOTHER (city or town) Manchester (State or country) England

14 Informant Husband (Address) 1704 Victory Ave.

15 Filed ..... 19.. C. HARRISON JONES, M. D. Registrar

By ..... Asst.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1929, to December 4, 1929, that I last saw him alive on December 4, 1929, and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension and Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

12/4/29 (Signed) M. C. Engelhardt, M. D.

(Address) 1704 Victory Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	Dec. 7 1929
20 UNDERTAKER Henry Sander & Sons Inc	ADDRESS Baltimore St & Broadway

5 – 1929

Be sure that all items are correctly and completely answered. Cause of death must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 51638

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1501 Holbrook ST. 9-18 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophie Brendel

(a) RESIDENCE NO. 1501 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred About 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: John Brendel

6 DATE OF BIRTH (month, day, and year): April 26, 1892

7 AGE — Years: 37 | Months: 7 | Days: 8 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: William Beyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Ezra Beyer

(Address) 1501 Holbrook St

15 Filed 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 4. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Dec 4, 1929, that I last saw h alive on Dec 4, 1929 and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension with duration 8 yrs. months

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

Dec 4, 1929 (Address) 4 Westminster Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 7, 1929

20 UNDERTAKER: Margaret E. Hynes ADDRESS: 1427 Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51639

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1610 Wilkins Ave. ST. 19-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Badger

(a) RESIDENCE NO. 1610 Wilkins Ave. ST., WARD

(Usual place of abode) Life

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Badger

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Ramsay

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Hamilan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Bertha Barber (Daughter

(Address) 704 N. Broadway

15 Filed 12-5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3, 1929

17

I HEREBY CERTIFY, That I attended deceased from 12/1/, 1929, to 12/3/, 1929,

that I last saw her alive on 12/3/, 1929

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) Hrs. 48 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Fury, M. D.

12/5/1929 (Address) 900 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec. 7. 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons, Inc.	Baltimore & Broadway

Cor.—12-9-25—A Co.—200 Bks.

E 51640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 51640

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 500 S. Wolfe St) (St.) 4 (Ward)

2-FULL NAME ~~Mina~~ Elizabeth Schulte

(a) RESIDENCE NO. 500 S. Wolfe St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Matz Christian Schulte

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katheline Christian

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mina E. Schulte

(Address) 500 S. Wolfe St

Filed Dec 6 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 2 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

Dec 29 (Signed) G C Biddle M. D.

(Coroner)

1929 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Druid Ridge	Dec 6 1929

20 UNDERTAKER	ADDRESS
Wm J Tackney & Son	North & Pa Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 51641

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH

E 51641

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1308 Upton ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vencent Logan

(a) RESIDENCE NO. 1308 Upton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 26 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Harry Logan

11 BIRTHPLACE OF FATHER (city or town) Balti-
(State or country) md

12 MAIDEN NAME OF MOTHER Alice Flemming

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Va

14 Informant Fary Logan

(Address) 1308 Upton St

15 Filed DEC 6 1929 H. [illegible] Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 4, 1929, that I last saw him alive on Dec 4, 1929 and that death occurred, on the date stated above, at 10-55 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Woodruff M. D.

12-5. 1929 (Address) 703 N Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Dec 6 1929

20 UNDERTAKER Samuel J Wensley ADDRESS 78 Bolton

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51642

CERTIFICATE OF DEATH

101-001 E 51642

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2397 W Biddle St. 11-24 Ward)

2-FULL NAME Wm A. Green

(a) RESIDENCE NO. 2397 W Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Mal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Fletcher Green

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Jessie Porter

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Jessie Green
(Address) 2397 W Biddle

15 Filed 1929 H. LESLIE JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 12/20 1929

20 UNDERTAKER Francis J Kennedy

ADDRESS 5781 Belair

Important. See instructions on back of certificate.

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

E 51643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 ✓ E 51643

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1223 E Madison ST 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Eppes

(a) RESIDENCE NO. 1223 E Madison ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vance Co. N.C.

PARENTS

10 NAME OF FATHER Drewry Eppes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Marie Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Drewry Eppes (Father)

(Address) 1223 E Madison St

15 Filed DEC 6 - 1929, 19 H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Dec 3, 1929, that I last saw h alive on Dec 2, 1929 and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

Dec 4, 1929 (Address) 1424 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	Dec 8 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1691 orleans st

Cor.—10-10-29—A Co.—100 Bks.

E 51644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101 E 51644

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1428 Riggs St., 16-27 Ward)

2-FULL NAME Alice B Bell

(a) RESIDENCE NO. 1428 Rigge St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of nobody

6 DATE OF BIRTH (month, day and year) Mar 5 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimd.
(State or country)

PARENTS

10 NAME OF FATHER Jas M. Bell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice Robinson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Alice Bell
(Address) 1428 Riggs St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 4th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Lamb, M. D.
Dec 5 '29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL Dec 6 1929.

20 UNDERTAKER Thomas E. Pelson — ADDRESS 1303 Pressman St

DEC 6 1929

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 51645

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Shadrick Dancy

(a) RESIDENCE NO. 759 W. Franklin st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Wm. Dancy

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lucy Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1929, to Dec. 4, 1929, that I last saw him alive on Dec. 4, 1929 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, acute

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature]

12-4, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem. DATE OF BURIAL 12-7 1929

20 UNDERTAKER Byron Wright ADDRESS 1218 McElderry St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51646

CERTIFICATE OF DEATH

31 ✓

REGISTERED NO. E 51646

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincente J. Sallozl

(a) RESIDENCE NO. Maryland Penitentiary WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. Unknown mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1870

7 AGE	Years	Months	Days	If LESS than 1 day,....hrs. or....min.
	59	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, bosiness, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Santiago
(State or country) Cuba

PARENTS

10 NAME OF FATHER Jose Sallos

11 BIRTHPLACE OF FATHER (city or town) Santa Clara
(State or country) Cuba

12 MAIDEN NAME OF MOTHER Marie Sanchez

13 BIRTHPLACE OF MOTHER (city or town) Santa Clara
(State or country) Cuba

14 Informant Md. Penitentiary Records
(Address)

15 Filed Dec 10, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929 to Dec 4, 1929, that I last saw him alive on Dec 4, 1929 and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical pathological lab.

(Signed) Joshua Hollmacost, M. D.

12/4, 1929 (Address) Woodlawn md.

*State the Disease Causing Death, or in deaths from Violent Caoses, state (1) Means and Nature of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 12/5, 1929

20 UNDERTAKER J. J. Feahey & Sons — ADDRESS 1318 Light St

Spec.--8-16-29—L. F. S.—100 Bks.

E 51647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

* 129 E 51647

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3325 Edmondson St. W-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriett A Lynn

(a) RESIDENCE NO. 3325 Edmondson ST., WARD Oakland Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lynn

6 DATE OF BIRTH (month, day, and year) [illegible] 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER J. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dix

12 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Grace

(Address) 3325 Edmondson Ave

15 Filed Dec 6 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 25- 1929, to Dec 4, 1929, that I last saw her alive on Dec 4 1929 and that death occurred, on the date stated above, at 2 37 m.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Howard Co

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Lynn, M. D.

12-6- 1929 (Address) Longton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL Dec. 6 1929

20 UNDERTAKER Mew & Son Inc. — ADDRESS Dykesville Md.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51648

CERTIFICATE OF DEATH

188-103

E 51648

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) John Hopkins Hospital St., 10-13 (Ward)

2-FULL NAME Solomon Baron

(a) RESIDENCE NO. 1400 Ashland Ave., St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Baron

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Raphael Baron

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Dora -------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Mrs. Jennie Baron (Wife)
(Address) 1400 Ashland Ave.,

15 Filed ..., 19... C. HAMPTON JONES
Registrar

C 6 1929

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
Upsetting into side of moving auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Ribs Multiple

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In 1400 Block Madison

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Braun M. D.

12/6, 1929 (Address) 2939 no. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 12-5-1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto. St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51649

CERTIFICATE OF DEATH

129 E 51649

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 610 N. Dallas St., 7-9 Ward)

2-FULL NAME Blanche Freeman

(a) RESIDENCE NO. 610 N. Dallas St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Freeman

6 DATE OF BIRTH (month, day, and year) July 4/1893

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
36	36	5	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Operator 086
(b) General nature of industry, business, or establishment in which employed (or employer) L. & M Cloak & Suit Co
(c) Name of employer

9 BIRTHPLACE (city or town) Crisfield
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Drummond

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Onancock, Va.

14 Informant George Freeman
(Address) 610 N. Dallas St

15 Filed ..... 19.... C. HAMILTON JONES, M. D.
Registrar

Dar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Nephritis (Chr)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

(Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL Dec 7 1929

20 UNDERTAKER John W Henderson

ADDRESS 1512 Edmondson

Oct 6 1929

Be it known, that in consideration of the premises, and of the powers vested in me by the Charter and Ordinances of the City of Baltimore, I do hereby grant unto the said Grantee, his heirs and assigns, the right to bury the body of the deceased in the above described lot, subject to the rules and regulations of the Commissioners of Greenmount Cemetery.

In Testimony Whereof, I have hereunto set my hand and affixed the seal of the Commissioners of Greenmount Cemetery, this 6th day of Oct 1929

Commissioners of Greenmount Cemetery

By [signature] Secretary

Be careful in your replies, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51650 HEALTH DEPARTMENT—CITY OF BALTIMORE

231510

CERTIFICATE OF DEATH X 32 ✓ E 51650

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Sikalis

(a) RESIDENCE NO. Salisbury - Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-5-18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	6	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Louis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Mary Samaras

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Record

(Address)

15 Filed 6-1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4-29

17 I HEREBY CERTIFY, That I attended deceased from 11-24, 1929, to 12-4-, 1929, that I last saw him alive on 12-4-, 1929 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 2 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Tbr. bacilli found in Spinal fluid

(Signed) J. C. Bickford Jr., M. D.

12/4. 1929 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 12/5 1929

20 UNDERTAKER George & Ruth

ADDRESS 1735 Aisquith

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51651

CERTIFICATE OF DEATH

74-001 E 51651

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 338 S. Calhoun ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Sexton

(a) RESIDENCE NO. 338 S. Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis Sexton

6 DATE OF BIRTH (month, day, and year) October 23, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Samuel Meredith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Henry

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Mary E. Deemer

(Address) 802 Fifth Ave., New Kensington, Pa.

15 Filed DEC 5 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/29, 19 29, to 12/5, 19 29, that I last saw her alive on 12/4, 19 29, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No —

What test confirmed diagnosis? None.

(Signed) H. Harry Meredith, M. D.

12/6/29 (Address) 11 N. Carey Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec. 7 19 29

20 UNDERTAKER [illegible]

ADDRESS 1003 West Baltimore St

Spec.—1-12-23—M&T—500 Bks.

B 51652

HEALTH DEPARTMENT—CITY OF BALTIMORE

6 001
100 E 51652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (ST.) 17-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pierre Duval

(a) RESIDENCE NO. 708 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
78				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant (niece) Mable Myers (Address) 708 W. Franklin St

15 Filed 12-6-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5— 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-1, 1929, to 12-5, 1929, that I last saw him alive on 12-5, 1929 and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brenner M. D.

Dec 8, 1929 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec. 7 1929
20 UNDERTAKER Henry Hauch Sons Inc.	ADDRESS 1301 E Eager

FOR A VERY important—See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 51653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Walter Carter

City of Baltimore: (No. 917 Hubbard Alley St. 10-13 Ward)

2-FULL NAME Walter Carter

(a) RESIDENCE NO. 917 Hubbard Alley St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3/27

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	2	1	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Eloise Butler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Eloise Carter
(Address) 917 Hubbard Alley

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) ..... yrs. ..... mos. 4? ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Pollen, M. D.

12/6/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL 12. 6 1929

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr onores
107 E. West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51654

CERTIFICATE OF DEATH

129 E 51654

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 434 E. Clement ST. 14 WARD 33)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George F. Litz

(a) RESIDENCE NO. 434 E. Clement ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Torch & Company

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George S. Litz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Frances Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs William J. May

(Address) 434 Clement St

15 Filed DEC 6 1929, 19 H. PEARSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1929, to Dec. 4, 1929, that I last saw him alive on Dec 3, 1929, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Myocarditis.

(duration) 1 days hours

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris M. D.

12.4. 1929 (Address) 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 7 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51655

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51655

CERTIFICATE OF DEATH

185

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. Belt's Rd ST., 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Pryor

(a) RESIDENCE NO. 135 E. Cross St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Pryor

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) Balto City Hosp

15 Filed DEC 8 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-29

17 I HEREBY CERTIFY, That I attended deceased from 11-21-, 19 29 to 12-5, 19 29

that I last saw her alive on 12-4-, 19 29

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

Fracture of left hip

by reason of slipping in the home accidentally (duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Psychosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry Fridenwald, M. D.

12/5, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakwood — DATE OF BURIAL 12/9 1929

20 UNDERTAKER Wm Lee — ADDRESS 1217 St Paul

Spec.—1-12-23—M&T—500 Blks.

E 51656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 51656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 St Mary ST. 17-24 WARD)

2-FULL NAME Alice Williams Price

(a) RESIDENCE No. 534 St Mary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Price

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Household Work

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: Weston Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Williams

(Address): 534 St Mary St

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/5 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Dec 5, 1929, that I last saw her alive on Dec 3rd, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 12-6 1929

20 UNDERTAKER: Dennis Eccles — ADDRESS: 816 Pine

Spec.—1-10-21—M&T—1500 Blks.

E 51657

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51657

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 Brentwood Ave ST., 25-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Frank

(a) RESIDENCE NO. 1924 Brentwood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Frank

6 DATE OF BIRTH (month, day, and year): 1/10/1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Berlin Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Pfeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia Frank (Address) 1924 Brentwood Ave

15 Filed: 12/4 1929 H. MAURICE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Dec 3, 1929.

that I last saw h[illegible] alive on Dec 3, 1929,

and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm A Straus, M. D.

12/5, 1929 (Address) 190 Griffis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 12/6 1929

20 UNDERTAKER: Edward Joulson

ADDRESS: Washington Blvd

DEC 6 - 1929

ATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 51658

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Calaway Ave St. 15-63 WARD.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. McLean

(Residence in Baltimore: No. 3710 Calaway Ave

S. W 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Dec (Month) 15 (Day), 1849 (Year)

7-AGE, 79 yrs. 11 mos. 20 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Well-fare Worker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Johnston

(Address) 3710 Calaway Ave

15- Filed DEC 6 1929 FERGUSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10th 1929, to Dec 5th 1929, that I saw him alive on Dec 5th 1929, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Cancer (Descending Colon)

(Duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward Cummins M. D.

Dec 5, 1929 (Address) 3405 Coldspring Rd formerly 539 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Dec 7, 1929

20-UNDERTAKER Kerhamel & Lore ADDRESS 723 N Fulton Ave

Spec.—2-29-28—L. F. S.—500 2ks.

E 51659
L 37183

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 51659

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Haff

(a) RESIDENCE NO. 40 N. Washington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	13d	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Schuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address)

15 Filed 6 1929, C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-29

17 I HEREBY CERTIFY, That I attended deceased from 12-3-, 1929, to 12-5-, 1929 that I last saw him alive on 12-5- 1929 and that death occurred, on the date stated above, at 1 17 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Empyema, Pleural Effusion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture - Blood, pleural fluid

(Signed) Benj. E. Hodge, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 7 1929
20 UNDERTAKER W. W. E. Koppelman	ADDRESS 371 Ann St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51660

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. E 51660

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST 8-17 WARD)

2—FULL NAME Sara Burdette

(a) RESIDENCE NO. 1850 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ? 037

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Pa.

PARENTS

10 NAME OF FATHER Nathan Warfield

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) England

12 MAIDEN NAME OF MOTHER Margaret Coons

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) England

14 Informant Records L.
(Address) BALTIMORE CITY HOSPITALS

15 Filed 6-1-1929 19 C. Hayden Jones M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-29

17

I HEREBY CERTIFY, That I attended deceased from 10-23, 1929, to 12-3, 1929,

that I last saw her alive on 12-3, 1929

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Fatal

(duration) over 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Fin. C.C.

(Signed) Warren H. McLane, M. D.

12-7, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	12/7 1929

20 UNDERTAKER Wm Cook ADDRESS 1317 W Lanvale St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51661 — 90 — E 51661

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2815 Alameda St., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Seegruber

(a) RESIDENCE NO. 2815 Alameda ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Seegruber

6 DATE OF BIRTH (month, day, and year) July 30. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Binding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Knodler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Henry Mauken

(Address) 2809 Alameda

15 Filed 6-1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8. 1929 to Dec 7, 1929 that I last saw h alive on Dec 4 1929 and that death occurred, on the date stated above, at 12 20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas. Smith, M. D.

12/9 19 29 (Address) 4 W Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Dec 10, 29

20 UNDERTAKER John Welrick

ADDRESS 2008 Orleans

Spec. -7-17-26--A Co.---200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51662

CERTIFICATE OF DEATH

X 129

REGISTERED NO. E 51662

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital Ward 11-24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna J. Disney

(a) RESIDENCE NO. 419 Walnut Rd St. Ward Balto Co Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~[illegible]~~ yrs. mos. / ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Cauc.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Andrew J. Disney

6 DATE OF BIRTH (month, day, and year): March 5, 1901

7 AGE: Years 28 Months 8 Days 29 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: James Walter Paul

11 BIRTHPLACE OF FATHER (City or town):
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Schmidt

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Maryland

14 Informant: Gen Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

DEC 6 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1929

17 I HEREBY CERTIFY, That I attended deceased from December 3, 1929, to December 4, 1929, that I last saw h.. alive on December 4, 1929, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) ? yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno C Wampler M. D.

19 (Address) 20 W Fayette Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Dec. 7 1929

20 UNDERTAKER: John F. Deany — ADDRESS: 715 Light St

Be certain all items are answered and that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 51663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 E 51663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 N. Wolfe ST. 1-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mariah Richardson

(a) RESIDENCE No. 909 N. Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: C

5 [redacted]arried, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Prince Richardson

6 DATE OF BIRTH (month, day, and year): May 25 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Everett City Georgia

PARENTS

10 NAME OF FATHER: Demas Wesley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Glenn Co Ga.

12 MAIDEN NAME OF MOTHER: Mariah Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Glenn Co. Ga.

14 Informant (Address): Leila Adams Daughter

15 Filed DEC 6 - 1929 H. Peck JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/5 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 - 1929 to Dec 5 1929

that I last saw h alive on Dec - 5 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 1 mos 0 ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Cert

(Signed) L. W. Walters M. D.

(Address) 4436 St Georges Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Everett City Ga

DATE OF BURIAL: Dec 8 1929

20 UNDERTAKER: Lotter-Sroos

ADDRESS: 1406 Ashland Ave.

Spec.–7-17-26—A Co.—200 Bks.

E 51664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51664

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2328 Mosher St. (Ward) 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Schmitt.

(a) RESIDENCE NO. 2328 Mosher St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George N. A. Schmitt

6 DATE OF BIRTH (month, day, and year) October 25 - 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	58	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, professinn nr particular kind of work At home

(b) General nature of industry, business, nr establishment in which employed (nr employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Paul Ludwig

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Remlein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Geo. N. A. Schmitt

(Address) 2328 Mosher St

15 Filed DEC 6 - 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 5 19 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 19 29 to Dec 5 19 29

that I last saw h alive on Dec 5 19 29

and that death occurred, nn the date stated abnve, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degen

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F. Blaufuss M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial 12/9 19 29

20 UNDERTAKER Chas F. Blaufuss & Son ADDRESS 1180 W. Mt Royal ave

If not entirely filled in with pen and ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51665

CERTIFICATE OF DEATH

100-001

REGISTERED NO. [illegible]

1-PLACE OF DEATH

City of Baltimore: (No. 1355 Carroll St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Henry Green

(a) RESIDENCE NO. 1355 Carroll St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5, 1929

7 AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
	3	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Chas. Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Lucy Roy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington D.C.

14 Informant Mrs Chas Green
(Address) 1355 Carroll St.

15 Filed 6-1929 H. LEMMON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Exposure

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

12/4, 1929 (Address) 360 1 St. W

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec. 6 1929

20 UNDERTAKER Mrs. P. G. Elliott ADDRESS 1715 Eastern Ave

Spec.-7-17-26—A Co.—200 Bks.

Dashields

E 51666

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51666

CERTIFICATE OF DEATH

10-001

REGISTERED NO. 25-72

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 Sycamore St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Dashields.

(a) RESIDENCE NO. 1502 Sycamore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 15 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): July, 27, 1927.

7 AGE: Years 2, Months 4, Days 15. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: William W. Dashields

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louise Fisher

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Md

14 Informant: William Dashields.

(Address): 1502 Sycamore St.

15 Filed: 6 - 1929 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Dec. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1929, to Dec. 5, 1929, that I last saw him alive on Dec. 5, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diptheria

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

Exhaustion (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

Dec 6 1929 (Signed) R. S. H. Cawthorne, M. D. (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baldar Hill Cem. Date of Burial: Dec 6 1929

20 UNDERTAKER: C. Howard Evans ADDRESS 388 Hanover

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 51667

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1823 Bank ST. 2-4 WARD)

2—FULL NAME Charles A. Jablitz

(a) RESIDENCE NO. 1823 Bank ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 9 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Barbara Jablitz

6 DATE OF BIRTH (month, day, and year) Dec. 9. 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lubitz Reliable

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christopher Jablitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ambrosia Jablitz

(Address) 1823 Bank Street

15 Filed DEC 6 1929, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1929, to Dec 5th, 1929, that I last saw him alive on " 5th, 1929 and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. Green, M. D.

12/6/29 (Address) 408 E. Eat Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuels Comet	Dec 8 1929
20 UNDERTAKER	ADDRESS
Louis Heemann	326 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 51668

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51668

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. 1148 Scott ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Rapp

(a) RESIDENCE NO. 1148 Scott ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 13, 1868

7 AGE: 61 Years 59 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Conrad Rapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Stengler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Reese (Sister)

(Address) 1148 Scott St.

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to Dec 4, 1929, that I last saw him alive on Dec 4, 1929 and that death occurred, on the date stated above, at 6:16 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhages

(duration) yrs. 8 mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ½ hr

18 Where was disease contracted if not at place of death? At Home -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Schottlaesche, M. D.

12/4, 1929 (Address) 1136 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 9 1929
UNDERTAKER George J. Smith	ADDRESS 1132 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

E 51669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 47

E 51669

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mabel Harrison

(a) RESIDENCE NO. Laurel Md. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank P Harrison

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Saml. H Valle

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary C Rawlings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant University Hospital
(Address) Laurel Md

15 FILED DEC 6 - 1929 C. HAMPSON JONES, M.D. Registrar

Reg. 4414

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1929, to Dec. 6, 1929, that I last saw her alive on Dec. 6, 1929 and that death occurred, on the date stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel T. Nelson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

DATE OF BURIAL Dec 9th 19 29

20 UNDERTAKER Elwood N Fisher

ADDRESS Laurel Md

Spec.—2-29-28—L. F. S.—500 Blks.

E 51670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 51670

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 W 33rd ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Loyd L. Davis

(a) RESIDENCE NO. 905 W 33rd ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Flora L. Davis

6 DATE OF BIRTH (month, day, and year) April 29 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	6 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Savage Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savage Md.

12 MAIDEN NAME OF MOTHER Lola Merchant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mildred L. Davis

(Address) 905 W. 33rd St

15 Filed 6-1929, 19 C. ELLISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1929, to Dec 5, 1929, that I last saw h[illegible] alive on Dec 5, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 1-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas Dewees, M. D.

Dec 6, 1929 (Address) 846 W 36th St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Cem Savage Md.	12/8/29
20 UNDERTAKER	ADDRESS
J. Wallace Davies	3307 Pennsy Ave

Spec.—1-10-21—M&T—1500 Bks.

E 51671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51671

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5122 Cordelia Ave. (WARD) 7-56

2-FULL NAME Louise Jacob

(a) RESIDENCE NO. 5122 Cordelia Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F Jacob

6 DATE OF BIRTH (month, day, and year) Mar 29. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	73	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Amrhein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Herring.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Edwin N. Jacob

(Address) 5122 Cordelia Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Dec 4, 1929.

that I last saw her alive on Dec 4, 1929.

and that death occurred, on the date stated above, at 7.22 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Hemorrhagic Nephritis

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J. Wells, M. D.

, 19 (Address) 5376 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL Dec 7. 1929

20 UNDERTAKER Mr & Mrs John W. Tempel & Son ADDRESS 801 W Fayette

TION is very important. See instructions on back of certificates.

Spec.--7-17-26--A Co.--200 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 51672

CERTIFICATE OF DEATH

× 90 C 51672

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Genl Hosp St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Wm C Brian

(a) RESIDENCE NO. Reisterstown, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Monica Brian

6 DATE OF BIRTH (month, day, and year): Aug. 3 1858

7 AGE — Years: 71 Months: 4 Days: 3 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Minister

(b) General nature of industry, business, or establishment in which employed (or employer): M.E 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Wm E. Brian

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Henrietta Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: See Hosp Records (Address)

15 Filed C. H. WILSON JONES, M. D. 19 Per MCH Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 December 6

17 I HEREBY CERTIFY, That I attended deceased from December 5, 1929, to December 6, 1929, that I last saw him alive on December 6, 1929, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

? (duration) ? yrs. ? mos. ? da.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) ? yrs. ? mos. ? da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. Edmund Weis, M. D.

12/6, 19 (Address) 1 W. Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial Dec. 9 1929

20 UNDERTAKER: Robt H Cook — ADDRESS 1003 W. Baltimore St

This certificate must be filed with the Registrar of the district in which death occurred within five days after death, and before any interment or removal of the body is made. Please print plainly, as much of it may be properly transcribed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51673

100-001 ✓

E 51673

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Franklin ST. 5-8 WARD)

2—FULL NAME Mr. Richard Deaver

(a) RESIDENCE NO. 331 N. Gay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida R. Deaver

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford County (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Deaver

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cassandra Richardson

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Mrs. Mollie C. Lenhard

(Address) 1808 W. Lafayette Ave.

15 Filed 6-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1929, to Dec. 6, 1929, that I last saw him alive on Dec. 6, 1929 and that death occurred, on the date stated above, at 1 0 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M Schreiber, M. D.

1277. 1929 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL DEc. 9, 1929

UNDERTAKER Harold Cook

ADDRESS 1003 N. Gay

Spec.—2-29-28—L. F. S.—500 Bks.

Beasley ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51674

CERTIFICATE OF DEATH

90 E 51674

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2333 N. Charles ST., 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Sidney Beasley

(a) RESIDENCE NO. 3363 N. Charles ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William F. Beasley

6 DATE OF BIRTH (month, day, and year): Oct. 15 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Louisville
(State or country): Kentucky

PARENTS

10 NAME OF FATHER: Robert Carson Hewitt

11 BIRTHPLACE OF FATHER (city or town): New York
(State or country)

12 MAIDEN NAME OF MOTHER: Johanna S. Anderson

13 BIRTHPLACE OF MOTHER (city or town): Lexington
(State or country): Kentucky

14 Informant: E. B. Beasley
(Address): Ruxton Md

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 8th, 1929, to Dec 6th, 1929

that I last saw h alive on Dec 6th, 1929

and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Endocarditis,

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): None ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferson Brack, M. D.

12/6, 1929 (Address) 5 Club Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. John's P. E. Greenmount Cem

DATE OF BURIAL: Dec. 7 1929

20 UNDERTAKER: Dept 18 Cook

ADDRESS: 1003 West Baltimore St.

Cor.—10-10-29—A Co.—100 Bks.

E 51675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1/79 E 51675

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 7-13 Ward)

2-FULL NAME Melba Prettyman

(a) RESIDENCE NO. 1026 Ashland Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23/1923

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Prettyman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Daisy Payne

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Daisy Prettyman
(Address) 1026 Ashland Ave

15 Filed 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns (Knees to eyes)

Clothes caught fire while playing with fire in kitchen stove.

Accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/6/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Dec 7 1929
20 UNDERTAKER	ADDRESS
Louis G. Johnson	716 N. Carey St.

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51676

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51676

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N. Mc Henry ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane C. O'Brien.

(a) RESIDENCE NO. 423 N. Henry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick O'Brien

6 DATE OF BIRTH (month, day, and year) Sept 3rd 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	2	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Andrew Geary.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Margaret Nolan.

(Address) 923 N. Henry St

15 Filed 1-7-1929 C. H. JONES M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15. 1929, to Dec 5. 1929, that I last saw her alive on Dec 5. 1929 and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) X yrs. X mos. 30 min

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? — no.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) H. Thaelborn M. D.

12/7, 1929 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec. 9 1929
20 UNDERTAKER John F. Cowan & Son	ADDRESS 900 Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

E 51677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1292 E 51677

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N. Robinson ST. 8-45 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaretha Bonacker

(a) RESIDENCE NO. 2862 Pelham Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced, HUSBAND or (or) WIFE of: late Philip Bonacker

6 DATE OF BIRTH (month, day, and year): Feb 2/54

7 AGE — Years: 75 | Months: 10 | Days: 4 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant: Mrs. E. H. Miller

(Address) 2862 Pelham ave

15 Filed ..., 19... Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6/29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1929, to Dec. 6, 1929, that I last saw h[e/r] alive on Dec. 6, 1929, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis
Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Nephritis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Clinical - Laboratory

What test confirmed diagnosis?

(Signed) H. Artigiani, M. D.

19 (Address) 2942 Efayette S

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem.

DATE OF BURIAL: Dec 9 1929

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51678

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-082 E 51678

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 N. Patterson Pk. Ave ST., 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Johanna M. Blum

(a) RESIDENCE NO. 836 N. Patterson Pk. Ave. STREET

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Philip Blum

6 DATE OF BIRTH (month, day, and year) May 1/1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ger.

10 NAME OF FATHER John Bohlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Madalene Reikirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

PARENTS

14 Informant Madalene Bohlman

(Address) 836 N. Patterson Park Ave

15 FILED DEC 7 1929 C. HAMPSON JONES, M. D. Registrar

7 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Dec 5th, 1929, that I last saw h alive on and that death occurred, on the date stated above, at 1.25 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cannot say definitely

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 7 ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. W. Hoffmeier M. D.

Dec 7, 1929 (Address) 4900 Dolfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Dec 7 1929

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51679

CERTIFICATE OF DEATH

101-001 E 51679

1-PLACE OF DEATH

City of Baltimore: (No. 1123 N. Mount St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Bell Jackson.

(a) RESIDENCE NO. 1123 N. Mount St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 3-1929

7 AGE: Years | Months 8 9 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER: Leroy Woodland

11 BIRTHPLACE OF FATHER (city or town): W. Va
(State or country)

12 MAIDEN NAME OF MOTHER: Taylor Jackson

13 BIRTHPLACE OF MOTHER (city or town): W. Va
(State or country)

14 Informant: Taylor Jackson
(Address): 1123 N. Mount

15 Filed ..... 19..... Registrar

1929

NRA

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Dec 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Peeples, M. D.

(Address) 606 Eutaw Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 12-7 1929

20 UNDERTAKER: Daniel Carter — ADDRESS 916 Eutaw ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51680

129

1-PLACE OF DEATH

City of Baltimore: (No. 415 W. Cross St. St. 21-31 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mina Bielstein.

(a) RESIDENCE NO. 415 W. Cross St. St., Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. ..... How long in U. S., if of foreign birth? 55 yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) December 16, 1853

7 AGE	Years	Months	Days 18	IF LESS than 1 day ..... hrs. or ..... min.
	75	11	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Henry Bielstein.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Schroeder

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany.

14 Informant J. Henry Gerstmeyer. (nephew)
(Address) 415 W. Cross St.

15 Filed ..... 19..... Registrar

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 4, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

12/6 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. — DATE OF BURIAL Dec 7 1929

20 UNDERTAKER E. Schloman & Son — ADDRESS 1039 Hanover

Spec.—2-29-28—L. F. S.—500 Blks.

E 51681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 √E 51681

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1806 Brunt ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatora Matassa

(a) RESIDENCE NO. 1806 Brunt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Santo Matassa

6 DATE OF BIRTH (month, day, and year) July 6 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Deco Valenzia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Barletta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Santo Matassa

(Address) 1806 Brunt St

15 Filed 1929 C. HERBERT JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Dec 6, 1929

that I last saw her alive on Dec 6, 1929

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi S. Di Stefano M. D.

Dec 7, 1929 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	12/9 1929
UNDERTAKER Geo J Ruth	ADDRESS 1736 Harford ave

Cor.—10-10-29—A Co.—100 Bks.

E 51682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1527 John St. 14-20 (Ward)

2-FULL NAME Eliza Watkins

(a) RESIDENCE NO. 1527 John St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 31-1844

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	85	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md.

PARENTS

10 NAME OF FATHER John Nicholas

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Green

13 BIRTHPLACE OF MOTHER (city or town) Annapolis Md
(State or country)

14 Informant Mrs Nine D. Schwatka
(Address) 702 Dryden Ave

15 Filed ..., 19... C. PHILIPSON JONES, M. D.
1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regulary

(Signed) M. Hopkins, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem — DATE OF BURIAL Dec 7" 1929

20 UNDERTAKER Jacob R. Cook — ADDRESS 1003 N. Eutaw

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51683

1—PLACE OF DEATH

CITY OF BALTIMORE: No. 3017 Northaway drive ST. 27-453 WARD

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Adolphus Hahn

(a) RESIDENCE NO. 3017 Northway drive ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 10 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Ida May Hahn

6 DATE OF BIRTH (month, day, and year) Jan 16th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble setter

(b) General nature of industry, business, or establishment in which employed (or employer) 076

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elvira Thorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ida M. Hahn

(Address) 3017 Northway drive

15 Filed 7-1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1929, to December 6. 1929. that I last saw him alive on December 5, 1929 and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Hilteral Hypertension

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy & Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination & Autopsy

(Signed) Albert Chairnes, M. D.

12/6, 1929 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 9th 1929

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Spec.—2-29-28—L. F. S.—500 Bks.

(Margaret Jane Jolliffe)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51684

CERTIFICATE OF DEATH

153 E 51684

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Jane Jolliffe

(a) RESIDENCE NO. 3405 Greenway (Geneva apts) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs 11 mos 11 ds. How long in U. S., if foreign birth? 13 yrs. 11 mos. 11 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 25 1915

7 AGE: Years 13 | Months 11 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Bowie Md Md.

PARENTS

10 NAME OF FATHER: Geo. J. Jolliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Winchester Va

12 MAIDEN NAME OF MOTHER: Harriette Ramsburgh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Maryland

14 Informant: Geo Jolliffe - Father

(Address): Geneva Apts.

15 Filed: 1929 Registrar: C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1929, to Dec. 7, 1929, that I last saw her alive on Dec. 7, 1929 and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Upper Lip

(duration) yrs. mos. 9 da.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/7/29, 12/1/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

Dec. 7 1929 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md — DATE OF BURIAL: Dec 8 1929

20 UNDERTAKER: Stewart & Co — ADDRESS: Baltimore

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51685

CERTIFICATE OF DEATH

E 51685

1—PLACE OF DEATH Provident Hospital

REGISTERED NO. 1-004

CITY OF BALTIMORE: (No. 1514 Division ST.) (WARD) 7-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton Mollock

(a) RESIDENCE NO. 814 Rutland ave ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Mollock

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O+O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John I. Mollock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Ennells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Esther Mollock

(Address) 814 Rutland ave.

15 Filed 7 - 1929, 19 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Dec 2, 1929, that I last saw h.. alive on Dec 5 1929 and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Laboratory A)

about 3 weeks (duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of -

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Laboratory

(Signed) Bernard Harris, M. D.

12/5, 19 29 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md.	Dec 7 1929
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 1725 Eastlander

Spec.—2-29-28—L. F. S.—500 Blks.

E 51686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51686

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 St. Paul ST. 11-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Recording Clerk

(a) RESIDENCE NO. 516 St. Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	65	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Emil Dubois

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Virginia Hebuterne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mary Credit

(Address) 516 St. Paul St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/29

17 I HEREBY CERTIFY, That I attended deceased from 10/14/29, to 12/5/29, that I last saw h[illegible] alive on 12/4/29 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. T. Hartman M. D.

12/6, 1929 (Address) 912 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec. 9 1929
20 UNDERTAKER Mrs. R. G. Elbert	ADDRESS 1725 Eastland Ave

Cor.—10-10-29—A Co.—100 Bks.

E 51687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 / E 51687

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 221 N. Fremont Ave 4-7a Ward)

2-FULL NAME John Turner

(a) RESIDENCE NO. 221 N. Fremont Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Daisy Turner

6 DATE OF BIRTH (month, day, and year) Jan 1 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer O&O
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Frank Turner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Agnes Jackson

13 BIRTHPLACE OF MOTHER (city or town) Louisa Co
(State or country) Va

14 Informant John E. Watkins
(Address) 732 N. Gilmor St

15 1929 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

12/7, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 7, 1929
20 UNDERTAKER	ADDRESS
Mrs. Kate R. Williams	3220 Schroeder St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51688

CERTIFICATE OF DEATH

90 ✓ E 51688

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1814 Warwick Av ST. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Waller

(a) RESIDENCE NO. 1814 Warwick Av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frank C. Waller

6 DATE OF BIRTH (month, day, and year): Sept 24-1875

7 AGE — Years: 54 | Months: 2 | Days: 11 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Theodore Forman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Rebecca Knoop

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Baltimore Md

14 Informant: Mr. Frank C. Waller

(Address) 1814 Warwick Av

15 Filed 1929 C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to Dec 5, 1929, that I last saw her alive on Dec 4, 1929, and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Chr. valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. W. Forte, M. D.

12/6, 1929 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mayfield Cemetery Co

DATE OF BURIAL: Dec 8 1929

20 UNDERTAKER: H. S. Marshall

ADDRESS 3539 Fall Rd

Spec.—2-29-28—L. F. S.—500 Blks.

E 51689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128 ✓ E 51689

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Oxford St. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nancy Lemmy

(a) RESIDENCE NO. 504 Oxford ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe Ger. via

PARENTS

10 NAME OF FATHER George Lemmy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Essie Lemmy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Minnie Lemmy
(Address) 504 Oxford st.

15 FILED DEC 7 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Dec 5, 1929, that I last saw h— alive on Dec 4-1929, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Acute Glomerular Nephritis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Chemical & phys.

(Signed) Chas. J. Keller, M. D.

12-7-1929 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec. 7 1929

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51690

100-081

E 51690

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 581 W. Lee St. St.) 22-30 (Ward)

2-FULL NAME Earl Wallace.(C)

(a) RESIDENCE NO. 581 W. Lee St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 18 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) June 18, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Percy Wallace.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co. Md.

12 NAME OF MOTHER Mary Gross.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mary Gross.(C) mother.
(Address) 581 W. Lee St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D.
Registrar
-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 6, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
Unknown.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Eisenhardt, M. D.

12/6, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calary Cemtery	12/7 1929
20 UNDERTAKER Walter B. Spriggs	ADDRESS 1340 Hanover

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51691

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51691

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hospital Baltimore, Md. (ST.) 42-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Risdon E. Bloodsworth

(a) RESIDENCE NO. Laurel, Dela ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) June 25, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain 86

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co., Md.

PARENTS

10 NAME OF FATHER Risdon E. Bloodsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna M. Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records, U.S. Marine Hospital (Address) Balto., Md.

15 Filed 12-7-1929 C. PEMBERTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 19 29

17

I HEREBY CERTIFY, That I attended deceased from , 19 27 , to December 6 , 19 29 ,

that I last saw him alive on December 5 , 19 29 ,

and that death occurred, on the date stated above, at 4:20 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma, bronchial

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. & clinical

(Signed) Ralph E Porter, M. D.

12/6 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Vernon Md — DATE OF BURIAL 12-7 19 29

20 UNDERTAKER Ed B Harkins — ADDRESS 115 E Mott

TION is very important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51692

CERTIFICATE OF DEATH

A 118-09 E 51692

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 4-7 (WARD)

2—FULL NAME Oswald Hood Harney

(a) RESIDENCE NO. 412 St Paul ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 11 1878

7 AGE: Years 51 | Months 4 | Days 26 | If LESS than 1 day, ... hrs. or ..... min. 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mgr.

(b) General nature of industry, business, or establishment in which employed (or employer): Bakery

(c) Name of employer: Office

9 BIRTHPLACE (city or town) (State or country): La.

PARENTS

10 NAME OF FATHER: John Bell Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky

12 MAIDEN NAME OF MOTHER: Anna F Hennen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): La

14 Informant: Dr Chas H Harney

(Address) Phila Pa

Filed 12-7 1929, 19 ..... H. WOOD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-7-29

17 I HEREBY CERTIFY, That I attended deceased from 11-19, 1929, to 12-7, 1929, that I last saw him alive on 12-7, 1929 and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Peritonitis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) ..... yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-20-29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J Leyko, M. D.

12/7, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila Pa — DATE OF BURIAL: 12/7/29

20 UNDERTAKER: Forrye & Farley — ADDRESS: Fulton & Fayette

Spec.—1-12-23—M&T—500 Bks.

Meinstbier

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51693

E 51693

CERTIFICATE OF DEATH.

129 ✓

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 652 Bartlett Ave. 9-46 WARD)

2-FULL NAME Elizabeth Meinstbier

(a) RESIDENCE No. 652 Bartlett ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Michael Meinstbier~~

6 DATE OF BIRTH (month, day, and year) June 22, 1856

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73 yrs.	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Arold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nat. Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Wm. H. Shields
(Address) 652 Bartlett Ave

15 Filed 8 1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec-16, 1927, to Dec 5 1929, that I last saw h[illegible] alive on Dec 5 1929, and that death occurred, on the date stated above, at 9 24 m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis, Chronic Nephritis Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) Estelle Hemming M. D.

12/7 1929 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 9, 1929

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E. Eager St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51694

CERTIFICATE OF DEATH

90 E 51694

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 816 Shuter St., 7-13 Ward)

2-FULL NAME Frank Benda

(a) RESIDENCE NO. 816 Shuter St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	wjite	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Benda

6 DATE OF BIRTH (month, day, and year) Dec 25/1847

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	81	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Joseph Benda
(Address) 1703 N. Belnord Ave

Filed 08-1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Odema Longs - Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. [illegible], M. D.

12/7/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer — DATE OF BURIAL Dec 9 1929

20 UNDERTAKER August D. Tasek — ADDRESS 2436 Ashland Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51695

CERTIFICATE OF DEATH

129 E 51695

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 N Spring ST. 10-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. Richard Knight.

(a) RESIDENCE NO. 1214 N Spring ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sallie Knight.

6 DATE OF BIRTH (month, day, and year) about 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler tender

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Woodson Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Victoria Elivet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Knight (daughter)

(Address) 1214 N Spring st.

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/29

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to Dec 5, 1929, that I last saw him alive on Dec 4, 1929 and that death occurred, on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Myocarditis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Hypertension and Arteriosclerosis (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. K. Johnny, M. D.

12/6, 1929 (Address) 1429 E Monument

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cem	12-9th 1929
20 UNDERTAKER	ADDRESS
Chas M Skinner	1625 E Broad st

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51696

CERTIFICATE OF DEATH.

101-001 E 51696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 Collins ave St.) 10-11 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Mary Byrne

(a) RESIDENCE NO. 150 Collins ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Byrne

6 DATE OF BIRTH (month, day, and year) Dec 18 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Richards Matos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Shutchby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas J. Byrne

(Address) 150 Collins ave

15 Filed 1929 C. H. [illegible] JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to Dec 6, 1929, that I last saw her alive on Dec 6, 1929 and that death occurred, on the date stated above, at 2201 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F. T. Kyper, M. D.

, 19 (Address) 3321 Freak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Dec 9th 1929

20 UNDERTAKER Fred A. Erkenbrecher — ADDRESS 1031 Hanover St

Spec.—8-16-29—L. F. S.—100 Pks.

E 51697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51697

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 S. Bouldin ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Beil Sr.

(a) RESIDENCE NO. 933 S. Bouldin ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Clara E. Beil

6 DATE OF BIRTH (month, day, and year) Oct. 6th 1858

7 AGE Years	Months	Days 28	If LESS than 1 day, hrs. or min.
71	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Anthony Beil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anthony Beil Son

(Address) 933 S. Bouldin St.

15 Filed ..... 19 ..... JOHN JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from Novemb 19 29, to Dec 4 19 29

that I last saw h alive on Dec. 3 19 29

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows: ~~Heart Complaint~~ Chr. Brights Disease

H. E. Wolf (Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Cadaveric Sclerosis (Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard E. Wolf, M. D.

, 19 (Address) 3 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Dec 9th 1929
20 UNDERTAKER Lilly & Gilmore	ADDRESS 400 N. Wolfe St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 51698

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 254 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Kohler

(a) RESIDENCE NO. 2021 E. Lombard st. ST., 2 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work File clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Kohler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Kohler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14
Informant Hospital Records
(Address)

15
Filed ..... 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1929

17
I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1929, to Dec. 5, 1929, that I last saw her alive on Dec. 5, 1929 and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. Garland Jr. M. D.

12-6, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemt	Dec 10 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc	403 S. Wolfe

Spec.—8-16-29—L. F. S.—100 Bks.

E 51699 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

74-001 ✓

CERTIFICATE OF DEATH

E 51699

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2427 E Hoffette ST., 6-1D WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry J Woerfler

(a) RESIDENCE NO. 2427 E Hoffette ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kunigunda Woerfler

6 DATE OF BIRTH (month, day, and year) April 7-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Business.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Woerfler

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Kunigunda Woerfler
(Address) 2427 E Hoffette St.

15 Filed DEC 8 - 1929 THOMAS JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5th/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 25th, 1929, to Dec 5, 1929, that I last saw him alive on Dec 5, 1929 and that death occurred, on the date stated above, at 12 PM m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension
Cerebral Apoplexy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Myocard Insuff. Pul. Edema. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. E. Geyer, M. D.

, 19 (Address) 561 N. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Dec 9 1929

UNDERTAKER Lully & Zeller Inc

ADDRESS 407 S. Wolfe

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51700

CERTIFICATE OF DEATH.

113 E 51700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Lutland St. 15-61 WARD)

2-FULL NAME Baby magazyner

(a) RESIDENCE No. 2855 W. Harrison Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 29-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Jos. Magaynir

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rose —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. Levin
(Address) 1739 Balto. St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1929

17 I HEREBY CERTIFY, That I attended deceased from nov. 7, 1929, to Dec. 7, 1929, that I last saw him alive on Dec. 7, 1929 and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

acute enterocolitis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & lab.

(Signed) Lt. G. Ettor, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen Circle, Hebrew St. Carmel	12-8, 1929

20 UNDERTAKER Jack Levin ADDRESS 1739 E Balto. St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51701

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51701

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2019 Presbury ST. 15-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Fredder

(a) RESIDENCE NO. 2019 Presbury ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William Fredder

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant Jose Lewis

(Address) 1439 E. Balto St

15 Filed [illegible] 19 [illegible] JONES, C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 7-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Dec. 7, 1929

that I last saw h[illegible] alive on Dec. 6, 1929

and that death occurred, on the date stated above, at 10 05 A.M.

The CAUSE OF DEATH* was as follows:

Mastoiditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Passagno M. D.

12.7.1929 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12-8-1929

20 UNDERTAKER Jose Lewis, 1439 E Balto. — ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 51702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51702

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Phillips

(a) RESIDENCE NO. 730 Dolphin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	~~married~~ single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day,....hrs. or.....min.
	60	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Walter Wiley (friend)
(Address) 730 Dolphin St

15 Filed — 1929 — CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12, 5 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Dec 5, 1929, that I last saw h.. alive on Dec 5, 1929 and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) about yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Undetermined (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Bernard Harris, M. D.

12/5, 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	12, 8 1929
20 UNDERTAKER Leon Hall	ADDRESS 753 Dolphin St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51703 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51703

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4019 Roland Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Holston

(a) RESIDENCE NO. 4019 Roland Ave. ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Holston

6 DATE OF BIRTH (month, day, and year): Feb. 2-1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
81	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 3 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Holston

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Mary J. Holston

(Address): 4019 Roland Ave.

15 Filed 8 DEC 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 7-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec 6, 1929, that I last saw h. im alive on Dec 6, 1929 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Bares, M. D.

12-7. 1929 (Address) 800 N 32nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Dec. 9 1929

UNDERTAKER: Horace F. Burgee

ADDRESS: 3631 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 51704

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51704

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Bon Secours Hospital ST., 19-26 WARD

2—FULL NAME Mrs Mary O'Toole

(a) RESIDENCE NO. 303 S. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John O'Toole

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patk Monaghan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cardaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John A Toole

(Address) 303 S Payson

15 Filed 1929 H. L. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6/29

17 I HEREBY CERTIFY, That I attended deceased from 12/5, 1929, to 12/6, 1929, that I last saw her alive on 12/6, 1929, and that death occurred, on the date stated above, at 10:35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Puerperal hemorrhage retained placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Child-birth Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. E. Stacy, Jr. M. D.

19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/9 1929
20 UNDERTAKER Forsyth & Farley Fulton & Fayette	ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51705

CERTIFICATE OF DEATH

× 111-002 ✓ E 51705

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Reginald Alvin Shanetts

(a) RESIDENCE NO. 15 Seminole Ave. ST., Catonsville WARD Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	28	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Sauce

(c) Name of employer New Process Co.

9 BIRTHPLACE (city or town) Baltimore, Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. R. Shanetts

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah B. Bannanzar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Charles R. Shanetts
(Address) 15 Seminole Ave Catonsville

15 Filed 8 1929 19 HERMAN JONES, R.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1929, to December 6, 1929, that I last saw h[illegible] alive on December 6, 1929 and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage, duodenal

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of Nov 28, 1929

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Stool Exam.

(Signed) Samuel McLanahan, M. D.

Dec 6 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemy.	Dec. 9, 1929
20 UNDERTAKER	ADDRESS
Chas. O. Mitchell & Sons	1920 Eutaw St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51706

CERTIFICATE OF DEATH

9V E 51706

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4002 Edmondson Ave 6-N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Hood Auld.

(a) RESIDENCE NO. 4002 Edmondson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh Auld

6 DATE OF BIRTH (month, day, and year) Nov 8. 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER John Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Miss Harriet Auld
(Address) 4002 Edmondson ave

15 Filed DEC 8 1929 HENRY M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 6, 1929, that I last saw h alive on Dec 6, 1929 and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Coronary Artery Occlusion

(duration) yrs. mos. 36 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. H. Lorimer Jr M. D.

12/7. 1929 (Address) 9 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 9. 1929
UNDERTAKER John C Mitchell & Son	ADDRESS 1900 Eutaw Place

Spec.—I-12-23—MAT—500 Blks.

E 51707 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

29 E 51707

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 1629 (Hospital, Institution or Private Residence) WARD)

2-FULL NAME Edward A. Evans

(a) **RESIDENCE** NO. 915 Lemmon street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ethel Combs

6 DATE OF BIRTH (month, day, and year) May 4, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work sexton 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph A. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Rawlings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Joseph A. Evans

(Address) 915 N. Lemmon St.

15 Filed DEC 8 - 1929 WILLISTON JONES, M. D. Registrar

Del CRM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1929, to Dec 6, 1929, that I last saw him alive on Dec 6, 1929, and that death occurred, on the date stated above, at 2:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis (Glomerular)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 29 ds. +

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? Blood, Urine & Physical

(Signed) Dennis H. Howard CC, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy.

DATE OF BURIAL Dec 9 1929

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51708 90 E 51708

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 607 W. 40th ST. 17-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Davis Long

(a) RESIDENCE NO. 607 W. 40th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. S. Long

6 DATE OF BIRTH (month, day, and year): Jan. 1853

7 AGE: Years 76 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James L. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Bessie Handy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. George H. King

(Address) 607 W. 40th St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Dec 6, 1929, that I last saw h[er] alive on Dec 6, 1929 and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.
Cardiac Decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension & Chronic Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Finnix, M. D.

Dec 7, 1929 (Address) 47 Hoffman Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Princess Ann. Md.

DATE OF BURIAL: Dec. 9, 1929

20 UNDERTAKER: John A. Mitchell & Sons

ADDRESS: 1400 E. Lan[illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51709

CERTIFICATE OF DEATH

101-001

E 51709

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3703 Spaulding Ave. ST. 15-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis T. Stone,

(a) RESIDENCE NO. 3703 Spaulding Ave. ST., WARD Carroll Co Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

5a ~~If married~~ widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary J. Stone.

6 DATE OF BIRTH (month, day, and year) April 19. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	79	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant David B. Stone
(Address) 3703 S Spaulding Ave

15 Filed DEC 8 - 1929 19 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1929, to Dec 6, 1929, that I last saw ~~him~~ her alive on Dec 6, 1929 and that death occurred, on the date stated above, at 2.38 P m.

The CAUSE OF DEATH* was as follows:

I Ilac Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sclr. Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Gilbert, M. D.

19 (Address) 478 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Shiloh, Carroll Co Md — DATE OF BURIAL 19

20 UNDERTAKER Robert S Sitte — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 51710 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 51710

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO. E 51710

CITY OF BALTIMORE: (No. 4-1 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas F. Bechdel (BECHDEL)

(a) RESIDENCE NO. 717 Mytenbrink Ave Pittsburg Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Ore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Chas Bechdel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Molly Grimslow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Burns Bechdel (Address) 717 Cumberland St

15 Filed C 8 1929 19 H. M. JONES, C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8/29

17 I HEREBY CERTIFY, That I attended deceased from 12-5, 1929, to 12-8, 1929

that I last saw h[illegible] alive on 12-8, 1929

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes 12

What test confirmed diagnosis? Clinical + autopsy.

(Signed) J Leyko, M. D.

12/8/1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loch Haven Pa	12/10 1929
20 UNDERTAKER J. F. Fahey & Sons	ADDRESS 1318 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 51711 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51711

CERTIFICATE OF DEATH.

91-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 Ruskin ave ST. 15-60 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ruth A. Petri

(a) RESIDENCE No. 2218 Ruskin ST., ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	mos	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Walty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Frank Petri (Address) New Windsor, Md.

15 Filed DEC 8 - 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Dec 8, 1929.

that I last saw h alive on Dec 7, 1929,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis

(duration) 5 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) E. W. Billups M. D.

, 19 (Address) 222 [illegible] North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville	Dec 10 1929
UNDERTAKER	ADDRESS
H. Steiner	New Windsor, Md.

Spec.—1-12-23—M&T—500 Blks.

E 51212

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST. 17-53 WARD)

REGISTERED NO. 100 801

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Daniel Duffy SS

(a) RESIDENCE NO. St Mary's Seminary ST. Belvidere & Roland WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1864

7 AGE — Years: 64 — Months: 11 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Catholic Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Rev. John F. Fenlon SS

(Address) St Mary's Seminary

15 Filed 12 - 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7- 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1929, to Dec. 7th, 1929, that I last saw him alive on Dec. 7th, 1929 and that death occurred, on the date stated above, at 4 12 P m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brennan, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Charles College Cemetery — DATE OF BURIAL: 12/10 1929

20 UNDERTAKER: Henry U. Mears and Son — ADDRESS: 805 N Calvert

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51713

CERTIFICATE OF DEATH

90 ✓

E 51713

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Ken Oak Road ST., 21-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Berry Kittle

(a) RESIDENCE NO. 2206 Ken Oak Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Childress

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
✓	68	9	15/4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York City

(State or country) New York

10 NAME OF FATHER Edward C. Kittle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York

12 MAIDEN NAME OF MOTHER Lydia Fagan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Mrs. Grace C. Kittle

(Address) 2206 Ken Oak Road

15 Filed DEC 9 - 1929 Roy JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1929, to Dec 6, 1929, that I last saw him alive on Dec 6, 1929, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fibrinous Bronchitis

? (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation

(Signed) Thomas J. Corman, M. D.

, 19 (Address) 1001 Eighth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	12/9 1929

20 UNDERTAKER Henry W. Meers & Son ADDRESS 805 W. Calvert

Spec.—1-12-29—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 51714

CERTIFICATE OF DEATH.

113 B 51714

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4175 Durham ST. 2-4 WARD)

2-FULL NAME Jan Fialkowski

(a) RESIDENCE NO. 4175 Durham ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4-29

7 AGE — Years: — Months: 4 Days: 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andy Fialkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Andy Fialkowski
(Address) 4175 Durham

15 Filed DEC 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1929, to Dec. 7, 1929, that I last saw him alive on Dec 7, 1929 and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Ileo-Colitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John V. Szczerbicki M. D.

(Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 9 1929

20 UNDERTAKER: F. W. Czazenski — ADDRESS: 1900 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51715

CERTIFICATE OF DEATH

170 ✓

E 51715

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem Hospital 94-20 St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Brilhartz

(a) RESIDENCE NO. 327 Mc Mechen St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White Sex	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha

6 DATE OF BIRTH (month, day, and year) Sept 7th 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	60	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Bertha Brilhartz
(Address) 327 Mc Mechen St

15 Filed ..., 19... ...
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound
Throat
Suicidal
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ..., M. D.
12/9/1929 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	12/9/1929
20 UNDERTAKER	ADDRESS
Wm Cook	127 St Paul

Important. See instructions on back of certificate.

DEC 9 1929

Spec.—1-10-21—M&T—1500 Blks.

E 51716 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51716

CERTIFICATE OF DEATH.

90V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. S.O. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Baker.

(a) RESIDENCE NO. 1216 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Baker

6 DATE OF BIRTH (month, day, and year) Oct 1895

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
34	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Alexander Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edith E. Baker

(Address) Mt Washington

15 Filed DEC 9 1929 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/30, 1929, to 12/7, 1929, that I last saw h/— alive on 12/7, 1929, and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Rheumatic cardio-valvular disease.

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical Exam.

(Signed) A. A. Gibson, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 12/9 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E. Fayette

IMPORTANT. See instructions on back of certificate.

Spec.—8-16-28—L. F. S.—100 Bks.

E 51717

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Seth [illegible] Hospital

E 51717

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 N Lanvale ST. 11-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Lee Louise Carey

(a) RESIDENCE NO. 207 N Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph D Carey

6 DATE OF BIRTH (month, day, and year) Feb 28. 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Josiah A Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Kate L Poling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Mervin D Dean

(Address) 207 N Lanvale St

15 C 9th - 1929. H. LEMMON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7. 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1929, to Dec. 7, 1929, that I last saw h or alive on Dec 6, 1929 and that death occurred, on the date stated above, at 8.45 m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? Carcinoma (duration) yrs. mos. da.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Gregory M Cook M. D.

12/7. 1929 (Address) 2430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 12/9 1929

20 UNDERTAKER J M Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51718

CERTIFICATE OF DEATH

71-001

E 51718

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Silver

(a) RESIDENCE NO. 1810 Jackson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	3 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infancy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md -
(State or country)

PARENTS

10 NAME OF FATHER John Silver

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Hortense ~~Wagner~~

13 BIRTHPLACE OF MOTHER (city or town) Md -
(State or country)

14 Informant Friends -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 12-9-1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4-29.

17 I HEREBY CERTIFY, That I attended deceased from 12-3, 1929, to 12-4, 1929, that I last saw h[illegible] alive on 12-4, 1929, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

12/4, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 7 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 51719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12 9 E 51719

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST. 27-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Noah Hyle

(a) RESIDENCE NO. 125 Oakdale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie E. Hyle

6 DATE OF BIRTH (month, day, and year) July 27, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) United R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Isaiah Hyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lawrence Hyle

(Address) 125 Oakdale Ave

15 Filed DEC 9 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8-29

17 I HEREBY CERTIFY, That I attended deceased from 12-6-, 1929, to 12-8, 1929, that I last saw h[illegible] alive on 12-8, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyhe, M. D.

12/9, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park	Dec 10 1929
20 UNDERTAKER Thanower Bros.	ADDRESS 3615 Chestnut Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51720

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 51720

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 10-14 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Williams

(a) RESIDENCE NO. 805 Somerset ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Robt. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mary Wilkison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed 12-9-1929 C. HILLSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-6-29

17

I HEREBY CERTIFY, That I attended deceased from 11-5-29, 19..., to 12-6-29, 19...,

that I last saw him alive on 12-6-29, 19...

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

over (duration) 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Aneurysm of Aorta

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ---

Was there an autopsy?

What test confirmed diagnosis? Hist. P.E. Lab

(Signed) Warwick M. McClean, M. D.

12-7, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cem. Overlea — DATE OF BURIAL: 12/9 1929

20 UNDERTAKER: Chas. A. Johnson — ADDRESS: 416 N. Caroline St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51721

CERTIFICATE OF DEATH.

100-001

E 51721

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 S. Robinson Street ST. 1-2 WARD)

2-FULL NAME Emma Haefner

(a) RESIDENCE NO. 18 S. Robinson Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Haefner

6 DATE OF BIRTH (month, day, and year) Sept 8, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Grolock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Grolock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. George Oberg

(Address) 18 S. Robinson Street

15 Filed Dec 9 1929 16 C. HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 29, 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Dec. 7, 1929, that I last saw her alive on Dec. 7, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of upper lip.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zollert, M. D.

12/8 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL 12/11 1929

20 UNDERTAKER Gilbert L Nitz ADDRESS 1606 N Chester

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 51722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 N. Caroline ST., 9-17 WARD)

2—FULL NAME Wilhelmina C. Hackemann

(a) RESIDENCE NO. 1800 N Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late George Hackemann

6 DATE OF BIRTH (month, day, and year) Aug 15th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER J. Kruse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Erdmann

(Address) 1800 N. Caroline

15 Filed Dec 9 1929

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Dec 6, 1929, that I last saw h alive on Dec 6, 1929, and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

CONTRIBUTORY (Secondary) Myocarditis & Edema (duration) yrs. mos. ds.

date

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clovis Jones, M. D.

12/7 1929 (Address) 42 N Hoffman Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Lawn.

DATE OF BURIAL Dec 9th 1929

20 UNDERTAKER George C. Pauls

ADDRESS 1735 Harford Ave.

Cor.—10-10-29—A Co.—100 Bks.

E 51723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51723

REGISTERED NO. 113 1947

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 813 - 1 Belgrade St., 27 Ward)

2-FULL NAME Lawrence E. Dill

(a) RESIDENCE NO. 813 - 1 Belgrade St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 11/22/29

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
✓	—	—	15	/

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Lawrence W. Dill

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Louise Middleoff

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Lawrence W. Dill
(Address) 813 - 1 Belgrade

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Gastro-Intestinal Indigestion,

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 503 E. Marta ave 12/9/29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec 9. 1929

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hollander

important. See instructions on back of certificate.

Spec. 2-20 [illegible] 500 Bks.

E 51724

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51724

30 v

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospital (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 76-39 ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joshua Greives

(a) RESIDENCE NO. 154 N. Haven st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Greives

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis A. Greives

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Sann

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 9 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to Dec. 7, 1929, that I last saw him alive on Dec. 7, 1929 and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Actinomycosis

Approx 1 yr. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas Thrasher M. D.

12-7-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Dec 10 1929

20 UNDERTAKER [illegible] & Ruth

ADDRESS 1735 Harford Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51725

CERTIFICATE OF DEATH

90 E 51725

1—PLACE OF DEATH

REGISTERED NO. 15-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3500 Fairview Ave ST., 15 WARD)

2—FULL NAME Chester L. Phillips

(a) RESIDENCE NO. 3500 Fairview Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie E. Moorhead

6 DATE OF BIRTH (month, day, and year) April 4 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	47	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mamie E. Phillips
(Address) 3500 Fairview Ave

15 DEC 9 - 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 7th, 1929, that I last saw h[illegible] alive on Dec 6th, 1929 and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical facts

(Signed) [illegible] M. D.

Dec 8 1929 (Address) 318 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy	Dec 9 1929
20 UNDERTAKER	ADDRESS 1419 Eutaw St.
John D. Mitchell & Sons	

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51726

CERTIFICATE OF DEATH

46 ✓

E 51726

1-PLACE OF DEATH

REGISTERED NO. 16-67

City of BALTIMORE: (No. Md. Gen. Hosp. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie Gregory Dennis

(a) RESIDENCE NO. 1639 Hilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Regan Milton Dennis

6 DATE OF BIRTH (month, day, and year) June 23-1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	61	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Henry Gregory

11 BIRTHPLACE OF FATHER (City or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Caroline Gen Wilson

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-6-29 19

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1929, to 12-6-29 19, that I last saw h[illegible] alive on 12-6-29, 19, and that death occurred, on the date stated above, at 8[45] A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vaginal wall.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Disease~~ General carcinomatosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial Dec 10 19 29

20 UNDERTAKER Wm Fluckner Son — ADDRESS [illegible]

very important. See instructions on back of certificates.

Spec.—3-29-28—L. F. S.—500 Bks.

E 51727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

153 ✓

E 51727

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irving Ray Hopkins

(a) RESIDENCE NO. Hanover Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy E. Hopkins

6 DATE OF BIRTH (month, day, and year) Sept 14 1882

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frunkemyr Co

PARENTS

10 NAME OF FATHER Henry Ray Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella L. Crook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucy E. Hopkins

(Address) Hanover Md

15 Filed 19 H. HOBSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 7, 1929, that I last saw him alive on Dec 7, 1929 and that death occurred, on the date stated above, at 9 30 P.M.

The CAUSE OF DEATH* was as follows:

Subpectoral abcess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 6th

Was there an autopsy? No

What test confirmed diagnosis? Operation, Blood culture

(Signed) Samuel J. Helms, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Frunkemyr Co Md

DATE OF BURIAL Dec 9 19 29

20 UNDERTAKER J. W. Nicholson Sons

ADDRESS Westminster

Spec.—2-29-28—L. F. S.—500 Bks.

E 51728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 51728

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 Harrison Blvd ST., 16-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anne Virginia Struven

(a) RESIDENCE NO. 2710 Harrison Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Martin Struven Jr.

6 DATE OF BIRTH (month, day, and year) March 5, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph C. Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edith Barrier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Charles M. Struven

(Address) 2710 Harrison Blvd.

15 DEC 9 - 1929 L. M. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1928, to Dec. 6, 1929, that I last saw her alive on Dec. 6, 1929 and that death occurred, on the date stated above, at 2.50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

Cardiac Dilatation

(duration) yrs. mos. 5 Hrs.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank H. Hurd, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Dec 9 1929

20 UNDERTAKER Wm. Tuckwell Sons ADDRESS Towson Md

Spec.—2-29-28—L. F. S.—500 Blks.

E 51729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51729

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Division ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Waters

(a) RESIDENCE NO. Raeyln, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1866 Guessed

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	68	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming.

(c) Name of employer Miss Bessie Myers.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Waters

11 BIRTHPLACE OF FATHER (city or town) Pikesville (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Campbell

13 BIRTHPLACE OF MOTHER (city or town) Reisterstown (State or country) Md.

14 Informant Georgia Fry.

(Address) 1510 Division St. Balto.

15 Filed DEC 9 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6/29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1929, to Dec. 6, 1929, that I last saw h.. alive on Dec. 6, 1929, and that death occurred, on the date stated above, at 8.10 A.m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio Vascular

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. J. Jackson M. D.

12/7, 1929 (Address) 6001 Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Thomas Lane	12/9 1929

20 UNDERTAKER ADDRESS

Frank P. Brantley 578 N. Carrollton Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51730

CERTIFICATE OF DEATH

160 ✓ E 51730

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1723 (Street) Madison (Ward) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Harris

(a) RESIDENCE NO. 1723 (Usual place of abode) Madison ST., WARD

Length of residence in city or town where death occurred yrs. mos. 19 How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER James Harris

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lola Mansell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant James Harris
(Address) 1723 Madison Ave

15 Filed DEC 9 1929 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 6, 1929
that I last saw her alive on Dec 6, 1929
and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH was as follows:

Icterus Neonatorum

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy?

What test confirmed diagnosis? ✓

(Signed) C. B. Hatch, M. D.

12/9 1929 (Address) 1005 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12/7 1929
20 UNDERTAKER	ADDRESS
Samuel J Lewis Lic	578 N Bond

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51731

CERTIFICATE OF DEATH.

90

E 51731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1033 Hanover St. 23-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Krauss

(a) RESIDENCE NO. 1033 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Henry E. Krauss.

6 DATE OF BIRTH (month, day, and year) April 16th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	67	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Fuhlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Henrietta Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ

14 Informant (Address) Henry E. Krauss 1033 Hanover st.

15 Filed 19 C 9 1929 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1929

17

I HEREBY CERTIFY, That I attended ~~deceased~~ from April 20th, 1929, to Dec 6th 1929, that I last saw ~~him~~ her alive on Dec 5th 1929, and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic aortic regurgitation of heart

(duration) — yrs. 7 mos 16 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Dorn Meibel M. D.

12/6, 1929 (Address) 1334-36 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Dec 9 1929

20 UNDERTAKER E Schlosman & Son ADDRESS 1038 Hanover

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51732

CERTIFICATE OF DEATH.

74 1001

E 51732

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Mem'l Hospital (St. or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry A. Wedi

(a) RESIDENCE NO. 2318 N Bonner St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Ella Rea Wedi

6 DATE OF BIRTH (month, day, and year): June 4 — 1871

7 AGE: Years 58 Months 6 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Bootshop

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City.

(State or country)

PARENTS

10 NAME OF FATHER: Henry Wedi

11 BIRTHPLACE OF FATHER (city or town): Balto. Co.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Zimmerman

13 BIRTHPLACE OF MOTHER (city or town): Balto Co

(State or country)

14 Informant: Ella R. Wedi

(Address) 2318 N Monroe St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Eugene Feller M. D.

(Coroner)

(Address) 2739 Eastern Ave

12-9, 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Dec 10 1929

20 UNDERTAKER: H S Marshall ADDRESS: 2539 Gall Rd

Very Important. See Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51733

CERTIFICATE OF DEATH.

B/E 51733

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 W 40th ST. 13-52 WARD

2-FULL NAME Edward Kearney Johnson

(a) RESIDENCE No. 1000 W 40th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 1st 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Phillip C. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mattie Kearney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. George (Sister)
(Address) 1000 W. 40th St.

15 Filed ....., 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7- 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-21- , 1929, to 12-7- , 1929,

that I last saw h[illegible] alive on 12-6- , 1929

and that death occurred, on the date stated above, at 4.20 A. m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical & Microscopical

(Signed) George E. Cross, M. D.

, 19 (Address) 28 W 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hanfield	Dec 10 1929
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fall Rd

C. H. HAMILTON JONES, M. D.

1929

Spec.—8-16-29—L. F. S.—100 Bks.

E 51734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4th E 51734

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 westwood ave ST., 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minty Gray

(a) RESIDENCE NO. 1721 westwood ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Gray.

6 DATE OF BIRTH (month, day, and year) march. 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	9 10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic. 27

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co md.

PARENTS

10 NAME OF FATHER Collins Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant William Gray.

(Address) 1721 westwood ave.

15 Filed 19 ELMER JONES, M. D. Registrar

DEC 9 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Dec 5, 1929, that I last saw h[illegible] alive on Dec 5, 1929 and that death occurred, on the date stated above, at 9 15 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

About (duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Chas C. Conser, M. D.

12/6, 1929 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 9 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1307 Eastman St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51735

CERTIFICATE OF DEATH

101-001

E 51735

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1506 Mosher St. 11-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gibson Jr

(a) RESIDENCE NO. 1506 Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician & Bb

(b) General nature of industry, business, or establishment in which employed (or employer) Piano player

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER Charles Gibson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Annandale W. Md

12 MAIDEN NAME OF MOTHER Ana Gant

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co

(State or country) Md.

14 Informant Elwood Gibson

(Address) 1506 Mosher St.

15 Filed ..... 19.. C. HAMILTON JONES, M. D. Registrar

DEC 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-6-1929

17 I HEREBY CERTIFY, That I attended deceased from 12-4- 1929, to 12-6- 1929.

that I last saw him alive on 12-6- 1929.

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Burton Saunders, M. D.

12-7- 1929 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — Date of Burial Dec 10 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1220 Pressman St

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51736

CERTIFICATE OF DEATH

100-001

E 51736

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore Gen'l Hospital ST., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Kiefer

(a) RESIDENCE NO. 26 Poultney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of John. D. Kiefer

6 DATE OF BIRTH (month, day, and year) Jany 8 - 186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Hornig

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Wilhelmina Hanke

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. Kiefer Son
(Address) 26 Poultney St.

15 Filed DEC 9 - 1929 WILLIAM R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8-29

17 I HEREBY CERTIFY, That I attended deceased from 12-3, 1929, to 12-8, 1929 that I last saw her alive on 12-8, 1929 and that death occurred, on the date stated above, at 5.05 A m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Generalized Arterio - Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Signs.

(Signed) Joseph L. Kiefer, M. D.

, 19 (Address) South Baltimore Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 12/10 1929

20 UNDERTAKER J. Fred McCully

ADDRESS 130 E. Fort

Spec.—1-10-21—M&T—1500 Bks.

Gunn.

51737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 E 51737

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 Druid ST., 11-24 WARD)

2-FULL NAME William Gunn

(a) RESIDENCE NO. 347 Druid ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov 6th. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Sparrows Point

(c) Name of employer Steel Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Baxter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sarah Gunn (Address) 347 Druid St

15 Filed 19 Registrar

C 9 1923 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/6/ 1923, to 11/7/ 1923

that I last saw h alive on 11/6/ 1923

and that death occurred, on the date stated above, at 12-12 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Pul. Tuberculosis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? N. Y. City

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

19 (Address) 624 Mod. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 12-8 1923

20 UNDERTAKER Kent Easton — ADDRESS 916 Park Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51738

CERTIFICATE OF DEATH

10-1001

E 51738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 576 Union St.) (Ward) 17-24

2-FULL NAME Martha Jackson

(a) RESIDENCE NO. 576 Union St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Wash D. C.
(State or country)

PARENTS

10 NAME OF FATHER John Hangelfield

11 BIRTHPLACE OF FATHER (city or town) Wash D. C.
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Jones

13 BIRTHPLACE OF MOTHER (city or town) Wash D. C.
(State or country)

14 Informant Edith Comfort
(Address) 1128 Druid Hill

15 Filed ... 1929 Registrar

Pat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Hunt, M. D.

Dec 7 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-10 1929
20 UNDERTAKER	ADDRESS
Daniel Carroll	941 Pa ave.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51739 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 51739

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Miller

(a) RESIDENCE NO. 1536 W North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) odo

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Germany

PARENTS

10 NAME OF FATHER ? Miller

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 FILED DEC 9 - 1929 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-29

17 I HEREBY CERTIFY, That I attended deceased from 12-4, 1929, to 12-7, 1929, that I last saw him alive on 12-7, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, acute ?

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. C.E. Lab.

(Signed) Warren M. McLean, M. D.

12-8, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	D 10 1929

20 UNDERTAKER Henry Keech & Sons ADDRESS 1301 E Eager St.

Cor.—10-10-29—A Co.—100 Bks.

E 51740

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51740

CERTIFICATE OF DEATH

1-PLACE OF DEATH Mud Hosp 21-29 188-10

City of Baltimore: (No. ..... St. 21 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Eagles

(a) RESIDENCE NO. 1153 N. Gross St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dont know

6 DATE OF BIRTH (month, day, and year) 9-18-1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Jno Bartel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs. Henry
(Address) 1152 W Gross St

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

9 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract Skull
Run down by auto truck

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Central Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Bayard & Hamburg

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Faucet, M. D.

12 8, 1929 (Address) 2939 W. Eddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	12-9-29

20 UNDERTAKER J. Heinecke & Son ADDRESS 520 N. Eutaw St

Spec.—1-12-23—M&T—500 Bks.

E 51741 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51741

CERTIFICATE OF DEATH. 101-500

1-PLACE OF DEATH St Agnes Hospital REGISTERED NO. 97-30

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (St.) (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Harp

(a) RESIDENCE NO. 225 S. Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Morris

6 DATE OF BIRTH (month, day, and year) Apl 17 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER John Harp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bucks Co. Pa

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Margaret Schwenger

(Address) 225 S Hanover

15 Filed DEC 9 1929 Registrar

C NO.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-4 1929 to 12-7 1929

that I last saw h.er alive on 12-7 1929

and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Left)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa. Dec 10 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51742

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 424 N Linwood ST., 6 (WARD)

2—FULL NAME Daniel W Hurley

(a) RESIDENCE NO. 424 N Linwood ST., Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Hurley

6 DATE OF BIRTH (month, day, and year) Sept 18 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jerome B Hurley
(Address) 424 N Linwood Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 19..., to Dec 7 29, 19..., that I last saw him alive on Dec 7 29, 19..., and that death occurred, on the date stated above, at 11 50 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Primary Heart Disease (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hugh B Hall, M. D.

Dec 9 29 (Address) 1303 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodford Co. Maryland

DATE OF BURIAL Dec 10 1929

UNDERTAKER John F. Denny

ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

E 51743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1003 E. Chase St., 8-13 Ward)

2-FULL NAME Elmer A. Keim

(a) RESIDENCE NO. 1003 E. Chase St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8/1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	33	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General naturo of industry, business, or establishment in which employed (or employer) 650
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Emil A. Keim

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Towson, Md.

12 MAIDEN NAME OF MOTHER Rose Kittenger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna.

14 Informant Emil A. Keim
(Address) 1003 E. Chase St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulm Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

12/7/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec. 9 1929
20 UNDERTAKER George N. Zirkle	ADDRESS 1737 E Eager St

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51744

CERTIFICATE OF DEATH

66 ✓ E 51744

1-PLACE OF DEATH

City of Baltimore: (No. 42 E. York St. St., 12-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Turner.

(a) RESIDENCE NO. 42 E. York St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If ~~married~~ widowed, ~~or husband~~ HUSBAND of ~~wife~~ Mary Turner.

6 DATE OF BIRTH (month, day, and year) April 2, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
✓	35	8	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Turner.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Mary O'Donnell.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard Co. Md.

14 Informant John H. Turner. (uncle)
(Address) 867 N. Howard St.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

09-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

12/9, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Dec 9 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St. Paul St.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51745

1—PLACE OF DEATH 1700 Eutaw place REGISTERED NO.

CITY OF BALTIMORE: (No. Navarre Apts. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Row

(a) RESIDENCE NO. Navarre Apts ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	79	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Row

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Richenberger

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Miss. Carrie Row
(Address) Navarre Apts

15 Filed DEC 9 - 1929 H. LESTER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from about Nov 6 1929, to Dec 7 1929,
that I last saw her alive on Nov 6 1929
and that death occurred, on the date stated above, at 4 1/2 P. m.

The CAUSE OF DEATH* was as follows:
Primal Arthritis; Arterio-Sclerosis
Cardiac Decompensation

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac failure
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical

(Signed) Geo. L. Peelman, M. D.

19 (Address) 224 E. 39th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem	12/9/1929
20 UNDERTAKER David Sondheim	ADDRESS 118-20 W. Mt. Royal Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 51746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 51746

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apt ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jeannette Evechel Frankel

(a) RESIDENCE NO. Esplanade Apt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 1 mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Frankel

6 DATE OF BIRTH (month, day, and year) Oct 23 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Importer of Lace

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Ferdinand Evechel

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Henriette Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sarah Iyams
(Address) Esplanade Apt

15 Filed EC 9 - 1929 H. LEMMON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Dec 7, 1929, that I last saw h.. alive on Dec 7, 1929 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chr Int Nephritis - Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Irwin S. Wagner, M. D.

12/9, 1929 (Address) Esplanade Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chev Shalom	Dec 10th 1929
20 UNDERTAKER	ADDRESS
Ward Bondheim	1211 Mt Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51747

CERTIFICATE OF DEATH

E 51747

1—PLACE OF DEATH Balto. City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Wendel

(a) RESIDENCE NO. 903 S. Curley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ?yrs. ?mos. ?ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19.. HAMPSON JONES, M. D.
per ..... Registrar

C 5 1626

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-29

17 I HEREBY CERTIFY, That I attended deceased from 12-2-29, 19.., to 12-7-29, 19..,
that I last saw him alive on 12-7-29, 19..
and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Infarcts of lungs.

(duration) ..yrs. ..mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..yrs. ..mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Harris M. McLaw, M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Dec 8 1929
20 UNDERTAKER	ADDRESS
Wendell & Heupel	300 E Cdn

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51748

CERTIFICATE OF DEATH

185 E 51748

1-PLACE OF DEATH

REGISTERED NO.

City of Baltimore: (No. B.& O.R.R.Coal Pier Curtis Bay. 1622 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. White.(C)

(a) RESIDENCE NO. 1024 N. Mount St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, HUSBAND of (WIFE of) Mary E. White.(C)

6 DATE OF BIRTH (month, day, and year) December 4, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
✓	62	0	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) B.O.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Henry White.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sylvia Tompkins.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina.

14 Informant Mary E. White.(C) wife.
(Address) 1024 N. Mount St.

15 Filed ... 19... C. HERBERT JONES, M. D. Registrar

C 9 - 1929.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 8, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Cervical Vertebrae.
Accidental fall at B.& O.R.R.Coal Pier.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto A. Steinhardt, M. D.

12/7 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 10, 1929
20 UNDERTAKER Samuel M. Chase & Son	ADDRESS 1400 Mosher

important. See instructions on back of certificate.

Spec.—2-19-28—L. F. S.—500 Blks.

E 51749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 V

E 51749

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 617 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Clark.

(a) RESIDENCE NO. 1927 N. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Ben Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Swoon ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records, (Address) Baltimore City Hospitals.

15 Filed 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 19 29, to Dec 7, 19 29.

that I last saw h[illegible] alive on Dec 7, 19 29

and that death occurred, on the date stated above, at 4:45 A.m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam & Lab.

(Signed) Warwick McClean, M. D.

19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Dec 9 1929.

20 UNDERTAKER Jno E Miller & Son

ADDRESS 2537 Pitts St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51750

CERTIFICATE OF DEATH

90 E 51750

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 534

CITY OF BALTIMORE: (No. ——— ST., ——— WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Poremski

(a) RESIDENCE NO. 8035 Broadway ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	? (About 45)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Matthew Poremski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dunie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Records Baltimore City Hospitals.

(Address)

15 Filed 9-1929 C. H. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1929, to Dec 6, 1929, that I last saw h.im alive on dec. 6, 1929, and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) Unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course + Lab.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas Cemetery DATE OF BURIAL Dec. 10 1929.

20 UNDERTAKER George A. Weber ADDRESS 105 S. Ann St.

Spec.—7-17-26—A Co.—200 Blks.

Douglass

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5175T

CERTIFICATE OF DEATH

90

E 5175T

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 211 Pickman St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Douglass.

(a) RESIDENCE NO. 211 Pickman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 27 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1867.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	62,	3,	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper. 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George W. Douglass.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lucinda Chambers.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England.

14 Informant Annie K. Douglass.

(Address) 211 Pickman St

15 Filed 9 - 1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1929 to Dec 7, 1929

that I last saw h[illegible] alive on Dec 6, 1929

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Hardening

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. A. Campbell M. D.

Dec 7. 1929 (Address) 164 E Hamburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial Dec 10, 1929

20 UNDERTAKER A. Ferman & Sons ADDRESS 38 E. Ford Ave

very important. See instructions on back of certificates. [illegible] STATEMENT OF OCCUPATION IS

Spec.—2-29-28—L. F. S.—500 Blks.

E 51752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 51752

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3 E. 33rd St. ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Schneider

(a) RESIDENCE NO. 3E. 33rd St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elenor Schneider

6 DATE OF BIRTH (month, day, and year) March 27 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. T. Cochrane

(Address) 110 E. 42nd St. N. Y.

15 DEC 9 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 — 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 — 1929, to Dec 8 — 1929

that I last saw h.. alive on Dec 8 — 1929

and that death occurred, on the date stated above, at 1.00 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferies Buck, M. D.

Dec 8. 1929 (Address) 5. Club Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Troy N. Y.	Dec. 9 1929
20 UNDERTAKER Harry N. Witzke 53	ADDRESS Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51753

CERTIFICATE OF DEATH

49 ✓ E 51753

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2922 Rosalie Ave ST. 7-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mark Ward Norman

(a) RESIDENCE NO. 2922 Rosalie Ave ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie H. Norman

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	64	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 69

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Mark Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Ely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant: Annie H. Norman

(Address) 2922 Rosalie Ave

15 Filed [illegible] 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to Dec. 5, 1929, that I last saw h living alive on Dec. 7, 1929, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

Approximate (duration) 1 yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) Cystitis - about 6 mos

Cystitis (duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? yes Date of May 31/29

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) A. M. Bacon, M. D.

12/8, 1929 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park & Strt

DATE OF BURIAL Dec 10 1929

20 UNDERTAKER W. M. Routson

ADDRESS 2238 N Mt

Spec.—2-29-28—L. F. S.—500 Bks.

E 51754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929

E 51754

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Homestead ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine A Boteler

(a) RESIDENCE NO. 622 Homestead ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	86	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Eric Eliason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Anna Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Grace E Carr

(Address) 622 Homestead

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929, to Dec. 8, 1929, that I last saw h.er alive on Dec. 7, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis

(duration) 7 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 4 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? X

What test confirmed diagnosis? Clinical

(Signed) Wm C. Clark M. D.

Dec 7, 1929 (Address) 2 W Pre apt. Charles Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Dec 10 1929
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51755

CERTIFICATE OF DEATH.

101-001 E 51755

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1719 W Fountain ST. 19-28 WARD)

2-FULL NAME Iva Nora Leishear

(a) RESIDENCE NO. 1719 W Fountain ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): April 6 1865

7 AGE: Years 64 Months 8 Days 1 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jas R. Leishear

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pr Geo. Co Md

12 MAIDEN NAME OF MOTHER: Susan Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Ruth Smith
(Address) 1719 W Fountain St

15 Filed DEC 9 - 1929 CLINTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 7, 1929.

that I last saw her alive on Dec 7, 1929.

and that death occurred, on the date stated above, at 12.37 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) M. O'Neill M. D.

12/8, 1929 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 10 1929

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins St

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 51756 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129 E 51756

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 W. Henrietta St. 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel M. Scanlon

(a) Residence No. 6 W. Henrietta St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Dc

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Motorman

(b) General nature of Industry, business, or establishment in which employed (or employer). Un Rys Co

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Daniel Scanlon

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Katherine McNamee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-

(Informant) Agnes M. Scanlon

(Address) 6 W. Henrietta St.

15-

Filed 3 - 1929

C. HAMPSON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 9-1929

17- I HEREBY CERTIFY, That I attended deceased from Nov 27- 1929 to Dec 9- 1929

that I last saw h.im alive on Dec 7- 1929

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis +

Chronic Granular Nephritis.

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. E. Brayton M. D.

12/9/ 1929 (Address) 304 E. Lovett St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. Dec 11-29

20-UNDERTAKER. Fred A. Peterman

ADDRESS 103 Hanover

Spec.—2-29-28—L. F. S.—500 Bks. Veronika Jendrazkiewicz E 51757

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51757

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., W-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Verna Anderson Jendrazkiewicz

(a) RESIDENCE NO. Ferndale, A.A. Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Whit	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing examiner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walenty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Rulkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Anderson

(Address) Ferndale a a co

15 DEC 9 1929 H. LESLIE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Dec 6, 1929

that I last saw h alive on Dec 6, 1929

and that death occurred, on the date stated above, at 11 30 p.m.

The CAUSE OF DEATH* was as follows:

Transverse myelitis of spinal cord (infection) T.C phalgia from waist down

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia, urinary tract infection, decubitus ulcer (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Dec 10 1929
20 UNDERTAKER	ADDRESS
M. W. E. Dupple	3 Lamb

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51758 ✓ 118-001 E 51758

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Gibson

(a) RESIDENCE NO. Simpsonville Md. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Gibson

6 DATE OF BIRTH (month, day, and year): Unknown 1897

7 AGE: 32 Years | — Months | — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Aaron Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Mary Woodcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hosp Records

(Address)

15 Filed DEC 9 1929, H. L. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/9/29.

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to Dec 9, 1929, that I last saw her alive on Dec 7, 1929 and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Incarceration Hernia (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/7/29

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & operation

(Signed) Henry F. Lewis, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Family Lawn

DATE OF BURIAL: Dec. 11, 29

20 UNDERTAKER: Easton Sons

ADDRESS: Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51759

CERTIFICATE OF DEATH

90 ✓ E 51759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 537 Moore St. 17-24 Ward)

2-FULL NAME Wm Slaughter

(a) RESIDENCE NO. 537 Moore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant A. W. Police Record
(Address)

15 Filed ... 19.. Register

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Hirsh, M. D.

(Address) 1st Dist. Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health — ADDRESS DEC 9 1929

Dep. Wm. E. WOODALL

important. See instructions on back of certificate.

U.S. MED. EXAM. H. LESLIE JONES, M.D.
1168 CITY MORGUE.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51760

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 4-76 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Ward

(a) RESIDENCE NO. 737 Mulberry st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER R. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Fannie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed DEC 13 1929 C. HAMBLETON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1929, to Dec. 3, 1929, that I last saw him alive on Dec. 3, 1929 and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Ghumrod Jr. M. D.

12-3, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

D. Commissioner Health. DEC 9 1929

Spec.—8-16-29—L. F. S.—100 Bks.

E 51761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 51761

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 E. 30th ST. 9-46 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Aloysius Fleming Casey.

(a) RESIDENCE NO. 1813 E. 30th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~1~~ yrs. ~~1~~ mos. ~~1~~ ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ethel Casey.

6 DATE OF BIRTH (month, day, and year) Aug 27-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. Dept Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Weston W. Va

PARENTS

10 NAME OF FATHER Francis P Casey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Weston W. Va

12 MAIDEN NAME OF MOTHER Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. A. F. Casey wife

(Address) 1813 E. 30th St.

15 Filed ..., 1929 C. HAMPSON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6. 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1926, to Dec 6, 1929, that I last saw ~~him~~ alive on Dec 6, 1929, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Leo Bellen M. D.

12.8. 1929 (Address) 1917 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem't — DATE OF BURIAL Dec 10 1929

20 UNDERTAKER Lillie Zitler Inc. — ADDRESS 403 E. Oliver St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51762

1—PLACE OF DEATH: Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST. 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Gus Stanley

(a) RESIDENCE NO. 9 Union ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed DEC 9 1929 C. HAMPSON JONES, Registrar

THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-2-29

17 I HEREBY CERTIFY, That I attended deceased from 7-26-21, 19____, to 12-2-29, 19____, that I last saw him alive on 12-2-29, 19____, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

over 11 mos. ds. (duration)

CONTRIBUTORY (Secondary) Arteriosclerosis

over 11 mos. ds. (duration)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. P.E.

(Signed) Warwick M. McLean, M. D.

12-4, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS DEC 9 1929

Per. Wm. E. Woodall

Spec.—2-29-28—L. F. S.—500 Bks.

E 51763

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 51763

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1725 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Coleman

(a) RESIDENCE NO. 632 Jasper ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Israel Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Mary Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed DEC 3 1929 C. HUMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-29

17 I HEREBY CERTIFY That I attended deceased from 11-25-29, 19..., to 12-5-29, 19...,

that I last saw him alive on 12-5-29, 19...

and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency.

Over (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam. Lab

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL DEC 5

UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 51764

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Olive Johnson

(a) RESIDENCE NO. 1137 Etting ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ?yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed DEC 9 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-5-29

17 I HEREBY CERTIFY, That I attended deceased from 9-3-21, 19..., to 12-5-29, 19..., that I last saw her alive on 12-5-29, 19..., and that death occurred, on the date stated above, at 10:15 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus.

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) over 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 12-7-29

20 DEC 9 1929

Daniel Easton
Commissioner Health

9/16 Patient

Spec.—2-29-28—L. F. S.—500 Bks.

E 51765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 51765

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lavina Jaffers

(a) RESIDENCE NO. 909 E. Madison ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Martha Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Hospital Record
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 9 1929 Registrar
4148

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-29

17 I HEREBY CERTIFY, That I attended deceased from 11-29, 1929, to 12-2, 1929, that I last saw h[illegible] alive on 12-2, 1929 and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Pelvic cellulitis - Acute salpingitis - Septicemia

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

12-2-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL DEC 9 1929

20 UNDERTAKER - Commissioner Health.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 51766

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51766

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 101

CITY OF BALTIMORE: (No. ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Williams

(a) RESIDENCE NO. 261 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Richard Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ....., 19 .....

4149 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-25-29, 19..., to 12-2-29, 19...,

that I last saw him alive on 12-2-29, 19...

and that death occurred, on the date stated above, at 9:55 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Aut. P.E. Lab

(Signed) Marvin M. McLean, M. D.

12-3, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NS HOPKINS HOSPITAL

DATE OF BURIAL ... 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

DEC 9 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51767

CERTIFICATE OF DEATH

24 ✓

E 51767

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 43-31 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Goldsborough

(a) RESIDENCE NO. 904 Hanover ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of ?
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 9-8-88

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~41~~ ? 41		2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment In which employed (or employer) ? 063

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Goldsborough

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md.

14 Informant Decarsol
(Address) BALTIMORE CITY HOSPITALS

15 Filed 9 1929, 19 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-29

17 I HEREBY CERTIFY, That I attended deceased from 8-13, 1929, to 12-7, 1929, that I last saw him alive on 12-7, 1929 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis
(Suspected)

..... (duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Yes Date of 11-23-29

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E. Lab. Autopsy Clinical Pleural

(Signed) Marvin M. McLean, M. D.

12-8, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

20 UNDERTAKER Margaret L. Flynn

DATE OF BURIAL Dec. 10 1929

ADDRESS 1422 Light

Cor.—12-9-25—A Co.—200 Bks.

E 51768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 51768

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 325-E 21 1/2 St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Montague

(a) RESIDENCE NO. 325-E-21 1/2 St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie A.

6 DATE OF BIRTH (month, day, and year) ? 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER James Montague

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Willie A. Montague

(Address) 325 E. 21½ St

15 Filed 19 C. HAMPSON JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

12-8, 1929 (Address) 322 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Point, Va. Date of Burial 12/10/1929

20 UNDERTAKER Mrs. Lu. H. Holland ADDRESS 1621 Druid Hill Ave

C 9 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 51769

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 51769

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Boileau.

(a) RESIDENCE NO. 1512 Fleet St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1891

7 AGE: Years 38 | Months 4. | Days 15. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0+0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila, Penna.

PARENTS

10 NAME OF FATHER Robert Boileau.

11 BIRTHPLACE OF FATHER (city or town) Phila. (State or country)

12 MAIDEN NAME OF MOTHER Lily Fisher

13 BIRTHPLACE OF MOTHER (city or town) Coppersville Pa. (State or country)

14 Informant Robert H. Boileau
(Address) 2832 N. 26th St Philadelphia

15 [illegible] 19 [illegible] Registrar

- 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Dec 9, 1929, that I last saw him alive on Dec 9, 1929 and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with uremia
7 8 days duration Lobar Pneumonia 9
9 days duration

Nephritis Chronic (Uremia) (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

12/9, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa — DATE OF BURIAL: 12/9 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St. Paul

Spec.–7-17-26—A Co.—200 Bks.

E 51770

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51770

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mt. Sen. Hosp. St. 16-67 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie L. Gambrill

(a) RESIDENCE NO. 3043 Belmont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
~~68~~ 69	69	-	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph G. Gambrill

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Jane Young

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Hospital Records

(Address)

15 C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 12-8-29

17 I HEREBY CERTIFY, That I attended deceased from 11-28-29 19 to 12-8-29 19

that I last saw her alive on 12-8-29 19

and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cholelithiasis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Hampton Lee M. D.

19 (Address) 720 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial Dec. 11 1929

20 UNDERTAKER Geo. H. Cook

ADDRESS 1003 W. Baltimore St

DEC 9 - 1929

Please print plainly, as that is may be property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51771 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51771

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2—FULL NAME Robert Jackson

(a) RESIDENCE NO. 1023 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE Negro | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Jackson

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Elias Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Baltimore City Hospitals

(Address)

15 Filed 12-9-1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4. 29 to Dec 8 29

that I last saw h alive on Dec 8 29

and that death occurred, on the date stated above, at 10 00 a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Left

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Luton

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Findings

(Signed) Harry Goodman M. D.

12/8 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elliott U. C. | DATE OF BURIAL 12-10 29

20 UNDERTAKER Samuel Carter | ADDRESS 916 Pa ave

Spec.—6-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51772

CERTIFICATE OF DEATH.

90 ✓ E 51772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 556 Baker St.; 44-59 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Silas

(Residence in Baltimore: No. 556 Baker St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1861
(Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, [redacted] Silas

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Hicks

(Address) 556 Baker St.

15-

Filed ..... (C. HARRISON JONES, M. D.) Registrar.

DEC 1929 Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1929, to Dec 7 1929, that I saw him alive on Dec 7 1929, and that death occurred, on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:

Valvula Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) [redacted]

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

Dec 9, 1929 (Address) [redacted] Balto. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 12-10-29

20-UNDERTAKER Daniel Carlon ADDRESS 946 Pa ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51773

101-001

E 51773

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 725 N. Vincent St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Hythe

(a) RESIDENCE NO. 725 N Vincent St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13-1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	10-11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Hythe

11 BIRTHPLACE OF FATHER (city Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Trehearne

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Minnie Trehearne
(Address) 725 N Vincent

15 Filed 10 G. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. Gelston M. D.

6-27-1927 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12-10-1929

20 UNDERTAKER Dennis Eastern

ADDRESS 916 E 21

9-1929

IF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51774

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2615 Wilkens av ST. 20-7 WARD)

2—FULL NAME Grace N. Ebaugh

(a) RESIDENCE NO. 2615 Wilkens av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Ebaugh

6 DATE OF BIRTH (month, day, and year) July 31 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	54	4	7 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER H. M. Shipley

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Calvin C. Ebaugh

(Address) 2615 Wilkens av

15 Filed 9 - 1929 O. HUMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from for 4 19 29, to Dec 8, 19 29, that I last saw h er alive on Dec 7, 19 29 and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Aortic "

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. Gustav Dill, M. D.

12/9, 1929 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 10 1929
20 UNDERTAKER John O Mitchell and Sons	ADDRESS 1900 Eastern Ave

Spec.—1-12-23—M&T—500 Blks.

E 51775 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 51775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Garrison Blvd ST. 15-63 WARD)

2-FULL NAME Mark H. Davis

(a) RESIDENCE NO. 3603 Garrison Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E Davis

6 DATE OF BIRTH (month, day, and year) July 12/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	57	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Fort Howard Paper Co

(c) Name of employer Green Bay Wis.

9 BIRTHPLACE (city or town) (State or country) Boonsboro Md.

PARENTS

10 NAME OF FATHER Trusty J Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriett Brantner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E Davis (Address) 3603 Garrison Blvd

15 Filed 9 1929. 19 C. HUMPSON JONES M Registrar

RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 8, 1929,

that I last saw h alive on Dec 8, 1929,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Confumation Broken

(duration) Short time

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Anamnestic

(Signed) A. C. Emmert, M. D.

(Address) 4509 Fairfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 11 1929
20 UNDERTAKER Harry M Almarode	ADDRESS 4202 Ridgewood Ave

HOW IS VERY IMPORTANT See INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—2-29-28—L. F. S.—500 Bks.

E 51776

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51776

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1526 E. Madison ST. 14-20 WARD)

2—FULL NAME Virginia May Cooper (nee Young)

(a) RESIDENCE NO. 1526 E. Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elliott Cooper

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 642

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thornton Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Watkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Martha Young (mother)

(Address) 1526 E. Madison

15 Filed ....., 19.... C. HAMILTON JONES, M. D. Registrar

12-1-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-29

17 I HEREBY CERTIFY, That I attended deceased from 12-4, 1929, to 12-6, 1929, that I last saw her alive on 12-6, 1929, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Ch. Pulmonary Th.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

12-9, 1929 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 12-11 1929

20 UNDERTAKER Wm Chas G. Bailey — ADDRESS 114 Jefferson St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51777

E 51777

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St., 70-70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Page

(a) RESIDENCE NO. 120 Allamount St., Ward Ca

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col-	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER Chas. Richardson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Snowden

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Emanuel Scott
(Address) 120 Allamount

15 Filed Dec 9 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. D. Brooke, M. D.

Dec 7, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Huntingdon, Pa	Dec 10 1929
20 UNDERTAKER Mrs. Kate R. Williams	ADDRESS 322 Schroeder St

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 51778

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51778

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2640 Guilford Ave ST. 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thurlow Reed Gilmore

(a) RESIDENCE NO. 2640 Guilford Ave ST. 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William T. Gilmore

6 DATE OF BIRTH (month, day, and year): Nov 22 1879

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rot Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs T. Reed Gilmore

(Address) 2640 Guilford Ave

15 Dec - 1929

H. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 9, 1929, that I last saw h[illegible] alive on Dec 8, 1929, and that death occurred, on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH* was as follows: Cardiac insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Nephritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lonsdale Green M. D.

12-9, 1929 (Address) 2438 Maryland

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 12/10/29 19

20 UNDERTAKER: Bloomeart & Son

ADDRESS: 1051 N. Calvert St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 51779 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) ... ST., 57 (WARD)

REGISTERED NO. ...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Celmer

(a) RESIDENCE NO. Steinmers ST., Run MD WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Konstanty Celmer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Kropkowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Konstanty Celmer
(Address) Steinmers Run Md.

15 Filed 9-1929, 19... C. HAMPSON JONES, M. D., Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Dec 7, 1929, that I last saw h... alive on Dec 7, 1929, and that death occurred, on the date stated above, at 12 40 m.

The CAUSE OF DEATH* was as follows:

Streptococcus Hemolyticus
Septicaemia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Vincent Trevethan M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem. DATE OF BURIAL: Dec. 10 1929

20 UNDERTAKER: John M. Webster ADDRESS: Chester

THIS is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Dr Blair 3417 Broadway
Before 7 30

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51780

CERTIFICATE OF DEATH

90 E 51780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 316 South Duncan St., 1-3 Ward)

2-FULL NAME Antonetta Sophia Peterson

(a) RESIDENCE NO. 316 S. Duncan St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin P.

6 DATE OF BIRTH (month, day, and year) Dec 6th 1882

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
47	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Rouse

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Delarine Heintz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Martin P Peterson
(Address) 316 S. Duncan st

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock
Ends cardiac
& Pneumonia
(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

12/9/29 (Signed) H E Cradell, M. D.

. 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	12/12 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul st

DEC 10 1929

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51781

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51781

CERTIFICATE OF DEATH

00-001

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE (No. ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbur Fesler

(a) RESIDENCE NO. 1414 E. Preston ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Fesler

6 DATE OF BIRTH (month, day, and year): Oct 2nd 1880

7 AGE: Years 49 ✓ | Months 2 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant: Baltimore City Hospitals

(Address)

15 Filed DEC 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1929 to Dec 8, 1929

that I last saw h[illegible] alive on Dec 7, 1929

and that death occurred, on the date stated above, at 4 00 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

Alcoholic Delirium

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis

Acute Alcoholic Delirium (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Contracted

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goodman M. D.

12/8 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampstead Cemetery

DATE OF BURIAL: 12/11/1929

UNDERTAKER: Wm Cook 1217

ADDRESS: St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

2101

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Gark
Monroe + B. 7 Ohio

E 51782
1—PLACE OF DEATH

CERTIFICATE OF DEATH

91-007

E 51782
REGISTERED NO.

CITY OF BALTIMORE: (No. 410 N. Monroe ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Storm

(a) RESIDENCE NO. 410 N. Monroe ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Storm

6 DATE OF BIRTH (month, day, and year) May 30, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	55	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md

PARENTS

10 NAME OF FATHER John Opper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Kradee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Frederick Storm (Address) 410 N. Monroe St

15 Filed OCT 10 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 19 29, to Dec 7, 19 29, that I last saw h alive on Dec 6, 19 29 and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? N

Did an operation precede death? N Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical + Consultation

(Signed) Adelaide Gark, M. D.

, 19 (Address) 701 Glenmore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 10 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51783

CERTIFICATE OF DEATH

74 Vol 1

E 51783

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4514 Weitzel Ave Ward) 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbus West

(a) RESIDENCE NO. 4514 Weitzel Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret West

6 DATE OF BIRTH (month, day, and year) Jan 12th 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Randolph West

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Ida West

(Address) 4514 Weitzel Ave

15 Filed DEC 10 1929 H. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th 1929, to Dec 9th 1929, that I last saw him alive on Dec 8th 1929, and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 46 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy, M. D.

12-9. 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial 12/12/1929

20 UNDERTAKER William Cook ADDRESS 1217 St Paul St

very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—[illegible] Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51784 90 E 51784

E 51784

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital (St.) 27-30 (Ward)

2-FULL NAME Alexander Gibbs

(a) RESIDENCE NO. 606 N. Lee St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk 1867

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Richard H. Gibbs

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret A. Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Stiffie Washington
(Address) 608 W. Lee St

Filed DEC 10 1929 H. LAWSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

A Myocarditis

(duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Dec 7 1929 Md Examined

(Signed) G. L. B. Eades M. D.

19 (Address) 1436 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	12-10 19 29
20 UNDERTAKER John H. Stallman	ADDRESS 1027 Round Hill

Spec.—2-29-28—L. F. S.—500 Bks.

51785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1143-002

E 51785

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ... ST. 4-7 ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Gardiner

(a) RESIDENCE NO. Clarksville Md ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. mos. 3 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Gardiner

6 DATE OF BIRTH (month, day, and year) Dec. 26. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife — 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Manakee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lottie Demmade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Hosp. Records

(Address)

15 Filed DEC 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17

I HEREBY CERTIFY, That I attended deceased from 11-27, 1929, to 12-10, 1929,

that I last saw her alive on 12-10, 1929

and that death occurred, on the date stated above, at 7:5 A m.

The CAUSE OF DEATH* was as follows:

Ectopic Pregnancy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Ye - Date of 11-29-29 12-5-29

Was there an autopsy?

What test confirmed diagnosis? Clinical & Operative.

(Signed) J. Leyko, M. D.

12/10, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Louis Church Cem	Dec. 12, 1929
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51786 — 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 N Carey ST. 19-26 WARD)

2—FULL NAME Julia Antoinette Wilson

(a) RESIDENCE NO. 238 N Carey ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 91 yrs. 10 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO. E 51786
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: David Wilson

6 DATE OF BIRTH (month, day, and year): January 11 1838

7 AGE: Years 91 | Months 10 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS
10 NAME OF FATHER: Elijah Stanton
11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn.
12 MAIDEN NAME OF MOTHER: Rebecca Millington
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. J. Wilson
(Address) 238 N. Carey St.

15 Filed Dec 10 1929 — 16 [illegible] — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 7-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1929, to Dec 7, 1929, that I last saw h alive on Dec 7, 1929, and that death occurred, on the date stated above, at 12.10 P m.

The CAUSE OF DEATH* was as follows:
Entro Colitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.
Dec 9 1929 (Address) 62 W 40 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 10 1929

20 UNDERTAKER: W. J. Duckett & Sons — ADDRESS: Norfolk

Spec.—2-29-28—L. F. S.—500 Bks.

51787

HEALTH DEPARTMENT—CITY OF BALTIMORE

51787

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 24-609

CITY OF BALTIMORE: (No. 2521 Francis ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary L Streeter

(a) RESIDENCE NO. 2521 Francis ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Streeter

6 DATE OF BIRTH (month, day, and year) Aug. 30/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	81	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Howard Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Barnes

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Mahala Mary L Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md

14 Informant Wm E. Streeter

(Address) Riderstown Md

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9-29

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1927, to December 9 29

that I last saw her alive on Dec. 7, 1929

and that death occurred, on the date stated above, at 11:15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

Cystocarcinoma

Paresis bladder

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Unknown

(Signed) Eva Smith, M. D.

Dec 9 29 (Address) 1605 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Pleasant Carroll Co. Md	Dec. 11, 1929
20 UNDERTAKER	ADDRESS
Wm H. McKee Sons	Hanover Pa

HAMILTON JONES, M. D.

DEC 10 1929

E 51788

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51788

CERTIFICATE OF DEATH.

13-59 167-001

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2521 Druid Hill Ave. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin P. Berlin

(Residence in Baltimore: No. 2521 Druid Hill Ave., St.; yrs. 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Male	White	Widowed

6-DATE OF BIRTH. December 17 1857 (Month) (Day) (Year)

7-AGE. 72 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant Owner

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Berlin

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. ? Schmitt

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Oscar Berlin

(Address) 2521 Druid Hill Ave.

15-

Filed DEC 10 1929 C. H. JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6 1929 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Jones M. D. (Coroner.)

12-7-29 1929 (Address) 3633 Reisterstown Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 2521 Druid Hill Ave.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. Dec 10 1929

20-UNDERTAKER. Wm J Tuckey Sons ADDRESS 1 E Fayette

Spec.—8-16-29—L. F. S.—100 Bks.

501 Bishop York Rd Sheridan Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51789

CERTIFICATE OF DEATH

129 E 51739

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4709 York Rd ST 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Greene

(a) RESIDENCE NO. 4709 York Rd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha C.

6 DATE OF BIRTH (month, day, and year) March 29-1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Farm Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Abbington, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John W Greene

(Address) York Pa

15 Filed Dec 10 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to Dec 8, 1929,

that I last saw h[illegible] alive on Dec 8, 1929,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Ch Ast. Nephritis,

Chr. Myocarditis

(duration) 1+ yrs. mos. da.

CONTRIBUTORY (Secondary) Arth. Cardiac Arteriosclerosis

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. E. Bishop, M. D.

Dec. 12 9 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jarrettsville Md Old School Baptist Cemetery

DATE OF BURIAL 12/10/1929

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51790 38 ✓ E 51790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5801 Radecke Ave. 26-38 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. Radecke

(a) RESIDENCE No. 5801 Radecke Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Dietrich H. Radecke

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Radecke (Address) Franklin Ave.

15 Dec 10 1929 C. H. HUMPHREYS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Dec 8, 1929, that I last saw h[illegible] alive on Dec 8, 1929, and that death occurred, on the date stated above, at 10 [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia & coma & Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clark Bruce, M. D.

12/9 1929 (Address) 4 West Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 11 1929
20 UNDERTAKER	ADDRESS
Frederick Lanahan	Fulleton

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5179T

CERTIFICATE OF DEATH.

40E 5179T

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6305 Dietz Ave ST. 26-4 WARD)

2-FULL NAME Bernard C. Schwarzkopf

(a) RESIDENCE NO. 6305 Dietz ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B Schwarzkopf

6 DATE OF BIRTH (month, day, and year) Aug. 15 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	53	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer L. Gange & Bro

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John B Schwarzkopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary B. Ponte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary B. Schwarzkopf (Address) 6305 Dietz Ave

15 Filed DEC 10 1929 H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6th, 19.. to Dec 9th, 1929

that I last saw him alive on Dec 6th, 1929

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy + Paralysis

(duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

Mitral (duration) 5 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Visual Evidence

(Signed) D. A. Waldron, M. D.

, 19 (Address) 210 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 12 1929
20 UNDERTAKER	ADDRESS
Frederick Lanahan & Son	Fullerton

Spec.—2-29-28—L. F. S.—500 Blks.

E 51792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+90 E 51792

REGISTERED NO. 21-53

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 St Johns Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2—FULL NAME Harry Waterman Porter

(a) RESIDENCE NO. Md. Training School for Boys Loch Raven
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. 2 ds. 18 How long in U. S., if foreign birth? 1 mo 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Bauns Porter

6 DATE OF BIRTH (month, day, and year) May 18-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musical Instructor 068

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Train Sch. Boys

(c) Name of employer Harold E Donnell Supt

9 BIRTHPLACE (city or town) (State or country) Hartford, Conn

10 NAME OF FATHER Charles Porter

11 BIRTHPLACE OF FATHER (city or town) Hartford Conn
(State or country)

12 MAIDEN NAME OF MOTHER Amelia Jacobsen

13 BIRTHPLACE OF MOTHER (city or town) Providence RI
(State or country)

14 Informant Bernice J. Porter (daughter)

(Address) Stamford, Conn

15 Filed Dec 10, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Dec 9, 1929, that I last saw h[illegible] alive on Dec 9, 1929 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/9, 1929 (Address) 4206 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loch Raven Mt Cemetery	Dec 11 1929
20 UNDERTAKER John B. Spence	ADDRESS 1325 N Caroline St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Chas T. Hall 1276 Park Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51793

CERTIFICATE OF DEATH

E 51793 9 a.m.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3527 W. Hayward Ave (ST.) 27-55 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida M. Scott

(a) RESIDENCE NO. 3527 Hayward Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh R. Scott

6 DATE OF BIRTH (month, day, and year) Oct 29th 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Elisha D. Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza H. Brierly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Anna Kessler

(Address) 3527 W Hayward Ave

15 Filed 19 C. HAMILTON JONES, L. S.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Dec 9, 1929, that I last saw h[er] alive on Dec 8, 1929 and that death occurred, on the date stated above, at 3 A.C. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Gangrene

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles T. Hall, M. D.

. 19 (Address) 1274 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	12/11/ 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51794

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51794

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 13-34

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Naomi Levy

(a) RESIDENCE NO. 2539 McCulloh st. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Levy

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Annie Keys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed DEC 10 1929 G. HAYSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1929, to Dec. 5, 1929, that I last saw her alive on Dec. 5, 1929 and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas F Arnold M. D.

12-6, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemtry	Dec 10 1929

20 UNDERTAKER Ida Snyder ADDRESS 1708 Madison Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51795
1—PLACE OF DEATH

CERTIFICATE OF DEATH

16-22 129 E 51795

CITY OF BALTIMORE: (No. 1126 N. Fulton Ave. St., 16-22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabella C. Outland

(a) RESIDENCE NO. 1126 N. Fulton Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas P. Outland

6 DATE OF BIRTH (month, day, and year) July 28, 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	72	4	11	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Josephus Copeland

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Rachel Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mrs. Iola Haywood

(Address) 1126 N. Fulton Avenue

Filed DEC 1929 C. HARRY JONES, M. D. Registrar

Rec

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1929, to Dec 8th, 1929, that I last saw her alive on Dec 8th, 1929 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic rheumatism. (Chronic rheumatoid arthritis)

(duration) one yr. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) — yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical manifestations

(Signed) Wm. J. Sinclair, M. D.

, 19 (Address) 1701 N. Fulton Avenue

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec. 11 19 29

20 UNDERTAKER Ralph Cook

ADDRESS 1003 West Baltimore st

Cor.—10-10-29—A Co.—100 Bks.

E 51796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 51796
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1367 Whatcoat St. 15-22 Ward)

2-FULL NAME Fred. Mc Cothen

(a) RESIDENCE NO. 1367 Whatcoat St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1884

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about 45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unk

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N. N. Dist Police Rec'd
(Address)

15 Filed DEC 10 1929 19 C. HERMAN JONES, M. D. Registrar

4155

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 5 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(Apoplexy.) (duration) yrs.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular.
(Signed) H. Leitch, M. D.
Dec 5th 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS DEC 10 1929

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

51797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51797

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry B. Oliver

(a) RESIDENCE NO. none ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) West Virginia

PARENTS

10 NAME OF FATHER T. J. Oliver

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Evelyn Camper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Records of

(Address) Balto. City Hospitals

Filed DEC 10 1929, HERMAN L. JONES, M. D.
Registrar

1156

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-29

17 I HEREBY CERTIFY, That I attended deceased from 11-26-29, 19..., to 12-5-29, 19...,

that I last saw h... im alive on 12-5-29, 19...

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Chronic Bronchitis

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. Lab

(Signed) Marvin W McLean, M. D.

12-5, 19 29 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

...NS HOPKINS HOSPITAL — 19

20 UNDERTAKER — ADDRESS

Commissioner Health

DEC 10 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51798

CERTIFICATE OF DEATH

44 V

E 51798

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto city Hosp. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Addie Stewart

(a) RESIDENCE NO. 541 Mission Court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Scobie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record

(Address)

15 Filed C. H. [illegible] 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8-29

17

I HEREBY CERTIFY, That I attended deceased from 9-19, 1929, to 12-8, 1929, that I last saw her alive on 12-8, 1929 and that death occurred, on the date stated above, at 5 45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pharynx

Metastasis to Cheek

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

12-8, 1929 (Address) Balto city Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivy Auburn

DATE OF BURIAL 12/11 19

20 UNDERTAKER Mrs. Geo. A. Holland

ADDRESS 1631 Druid Hill

Spec.—2-29-28—L. F. S.—500 Blks.

E 51799 HEALTH DEPARTMENT—CITY OF BALTIMORE 14-201 E 51799

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Provident Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2 ST. 13-54 WARD)

2—FULL NAME Lottie Smith

(a) RESIDENCE NO. 2450 McCulloh ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col'd | 5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James

6 DATE OF BIRTH (month, day, and year): ? 1886

7 AGE: Years 43 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of indastry, business, or establishment in which employed (or employer): 68

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

10 NAME OF FATHER: James Wiggins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Bertha Saunders

(Address) 2450 Mc Culloh St

15 Filed DEC 10 1929 HERMAN JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1929 to Dec 9, 1929, that I last saw h[illegible] alive on Dec. 9, 1929 and that death occurred, on the date stated above, at 6.05 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

12/9, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westview, Va.

DATE OF BURIAL: 12/10/1929

20 UNDERTAKER: Mrs Geo. E. Holland

ADDRESS: 16 W Druid Pl

Spec.—1-10-21—M&T—1500 Blks.

E 51800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

107-003

REGISTERED NO. E 51800

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland ST. 15-58 WARD)

2-FULL NAME Acbe. & Riker

(a) RESIDENCE No. 3100 Rutland Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Ryker

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
41	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vienna Austria

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Mrs L Glazier

(Address) Forest Park P.O.

Filed C 1-0 1929 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/9, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11 10, 29, to 12-9, 1929, that I last saw h alive on 12-9, 1929, and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Lung abscess

(duration) yrs. 1½ mos ds. over

CONTRIBUTORY (Secondary) Stomach—ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N.

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sinai Park — DATE OF BURIAL 12/10 1929

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 Balto St

Spec.—8-16-29—L. F. S.—100 Bks.

E 51801 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 11-001 E 51801

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 W Shuter St. 16-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A Buchanan

(a) RESIDENCE NO. 1112 W Shuter St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie E Buchanan

6 DATE OF BIRTH (month, day, and year) Nov 23 1874

7 AGE Years 55 Months 10 Days 17 If LESS than 1 day, hrs. or min. 18 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elmore Co Md

PARENTS

10 NAME OF FATHER Jacob Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elmore Co.

12 MAIDEN NAME OF MOTHER Nannie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James A Buchanan

(Address) 1112 W Shuter

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6/29

17 I HEREBY CERTIFY, That I attended deceased from 12/4, 1929, to 12/6, 1929, that I last saw h[illegible] alive on 12/6 1929 and that death occurred, on the date stated above, at 11:30 PM.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Pneumonia

CONTRIBUTORY (Secondary) Cirrhosis (duration) yrs. 5 mos. de.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. F. Eble, M. D.

19 (Address) 1132 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL Dec 8 1929

20 UNDERTAKER James L Wright ADDRESS 1549 W Baltimore

Spec.—1-10-21—M&T—1500 Bks.

E 51802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 E 51802

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital St. (Ward) 13-5

2-FULL NAME Baby Infant Koerner

(a) RESIDENCE NO. 3112 Chesmont ave (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 19 hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond Willard Koerner

11 BIRTHPLACE OF FATHER (city or town) Alexa (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Margaret Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Seattle (State or country) Washington

14 Informant Raymond A. Koerner

(Address) 3112 Chesmont ave

15 Filed DEC 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 10 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-9-29 19 ... to 12-10-29 19 ...

that I last saw h-m alive on 12-10-29 19 ,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pyuria Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Hendrix M. D.

12/10 19 29 (Address) Keyser Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Dec. 10 19 29

20 UNDERTAKER Henry Hoech Sons Co. — ADDRESS 1301 E Eager

HON. Is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 51803

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51803

CERTIFICATE OF DEATH

29-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1404 W Lexington St. 14-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary J Hancock

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16, 1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	85	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Edward Hancock

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary A Patterson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs M E Baker

(Address) 1404 W Lexington

Date OCT 8 1929 C. HERBERT JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1929 to Dec 9, 1929

that I last saw h alive on Dec. 3, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin B Jones M. D.

. 19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. — Date of Burial Dec 11/29

20 UNDERTAKER George J Smith — ADDRESS 153 N Howard St

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51804

CERTIFICATE OF DEATH

31 E 51804

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 659 Haw ST. 27-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Schoolhaus

(a) RESIDENCE NO. 659 Haw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 1 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 9 1887

7 AGE: Years 42 Months 0 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Jacob Schoolhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore md

12 MAIDEN NAME OF MOTHER: Mary Heinemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore md

14 Informant: Mr Jacob Schoolhaus

(Address) 659 Haw st

15 Filed ... 19 ... E. L. JONES, P. Registrar

C 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1927, to Dec 7 1929, that I last saw him alive on Dec 7 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) John A. Buchmen, M. D.

19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 11 1929
20 UNDERTAKER: Fos Foersters Son	ADDRESS: 217 S. Pa...

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51805

CERTIFICATE OF DEATH

14-002

E 51805

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Hemlock Ave (St.) 27-43 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie M. Waller

(a) RESIDENCE NO. 2823 Hemlock Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 15. 1906

7 AGE: Years 23 | Months 9 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Co. Md.

PARENTS

10 NAME OF FATHER: Archie M. Waller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Co. Md.

12 MAIDEN NAME OF MOTHER: Eleanor E. Dashiell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Archie M. Waller

(Address) 2823 Hemlock Ave

15 Filed DEC 10 1929 19 JOHN JONES, E. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14. 1929 to Dec 8. 1929 that I last saw h/she alive on Dec 8. 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Chas J Brunk, M. D.

(Address) 4702 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: Dec 11 1929

20 UNDERTAKER: Wm. Geo. John W. Teufel & Son

ADDRESS: 801 W. Fayette

Spec.—1-12-23—M&T—500 Blks.

E 51806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto Grl. Hosp

CITY OF BALTIMORE, No. Payson & Dyer ST., WARD 27-55

REGISTERED NO. 16-0

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Praube

(a) RESIDENCE No. 2921 Elsinore Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-7-29

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
				45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Edw. Praube

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Maria Gray

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant

(Address)

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-7, 1929 to 12-7, 1929, that I last saw h alive on 12-7, 1929, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred L Jewett, M. D.

, 19 (Address) 2516 Penn. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

DEC 10 1929

10 1929 1:58

Cer.—10-19-29—A Co.—100 Bks.

E 51807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 166 E 51807

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp. St. 47 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Lofgas

(a) RESIDENCE NO. Walker Road (Usual place of abode) St., Ward

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mass

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 10 1929 G. HUMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DC. 10 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Injured by Caisson
Type

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Lt. T. Riley Turner, M. D.

D C 19 29 (Address) 1629 Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mary Churchill Cem. Charge of Body Co. M.R.G.B.R.R.

DATE OF BURIAL 12/10/1929

20 UNDERTAKER Wallis Funeral Home Mass DC

ADDRESS

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 51808 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51808

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2711 Barclay ST. 12-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Edgar Young

(a) RESIDENCE NO. 2711 Barclay St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amalia

6 DATE OF BIRTH (month, day, and year) May 3rd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosa M. Pfister

(Address) 2711 Barclay St

15 Filed DEC 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6th, 19 29, to Dec 8th, 19 29, that I last saw h— alive on Dec 8th, 19 29 and that death occurred, on the date stated above, at 8.45P m.

The CAUSE OF DEATH* was as follows:

Uraemia

Chronic Glomerulonephritis (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Geo Gregory Mc Lean, M. D.

12/10/29 (Address) 1401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 12/11/1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

Dieterich

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51809

CERTIFICATE OF DEATH

29

E 51809

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3525 Eaton Ave. ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nannette Dieterich

(a) RESIDENCE NO. 2120 Ashton St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gottlieb Dieterich

6 DATE OF BIRTH (month, day, and year) July 18, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	65	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Vogelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Gottlieb Dieterich

(Address) 2120 Ashton St.

15 Dec 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan., 1927, to Dec. 10, 1929 that I last saw h[illegible] alive on Dec 9th, 1929 and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Malignant Heart Disease.

Chronic Nephritis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Goldberg M. D.

12/10, 1929 (Address) 2210 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec. 13 19 29

20 UNDERTAKER Harry N. Ditzler, 1531 W. Lombard

ADDRESS

24

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51810

E 51810

CERTIFICATE OF DEATH

101-01

1-PLACE OF DEATH U. S. Marine Hospital 6-11

City of Baltimore: (No. ..... St., 6-11 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Vereker

(a) RESIDENCE NO. 145 N. Potomac St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Mc Donald

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1866

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
63	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer S. S. Dyne

9 BIRTHPLACE (city or town) Nova Scotia
(State or country) Halifax

PARENTS

10 NAME OF FATHER Lawrence Vereker

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annastatia Hannebery

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant U. S. Marine Hospital Boston
(Address)

15 Filed 12 10 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pneumonea Lobar
Beg. 12 Evening

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

12/10 1929 (Address) 5632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boston, Massachutts	Dec. 10, 1929
20 UNDERTAKER E. Leroy Stiffler & Sons	ADDRESS 125 E. North ave

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51811

CERTIFICATE OF DEATH

129 ✓ E 51811

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3004 Harford Avenue ST., 9-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A Chesley

(a) RESIDENCE NO. 3004 Harford Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1/19,1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	60	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William V. Chesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Story

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Matilda A. Gaupitz

(Address) 3004 Harford Ave

15 Filed 1 1 1929 H. M. JONES, M. D. Registrar

1 1 1929 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1929, to Dec 9, 1929, that I last saw h/w alive on Dec 9, 1929, and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. mos. 13 da.

CONTRIBUTORY (Secondary) Arterio-Sclerosis.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B O Hergog md, M. D.

12/10, 1929 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 12 | 12 1929

20 UNDERTAKER George J Ruth ADDRESS 1730 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

E 51812 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 51812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 Kuper Place (Street) 19-28 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Harnett

(a) RESIDENCE NO. 1413 Kuper Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Annie Buckley

6 DATE OF BIRTH (month, day, and year): Aug 1866

7 AGE: Years 63 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patk Harnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Annie Harnett (Address) 1413 Kuper Place

15 Filed 1-1-1929 H. C. HUBER JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to Dec 9, 1929, that I last saw him alive on Dec 9, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

12/ , 19 (Address) 108 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Dec 12 1929

20 UNDERTAKER: John J Cowan & Son

ADDRESS: 901 Hollins St

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 51813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97 E 51813

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 E North Ave ST., 4-18 WARD)

2-FULL NAME Elenora Tegler Monninger

(a) RESIDENCE No. 800 E North Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of George Monninger

6 DATE OF BIRTH (month, day, and year) July 6 1871

7 AGE: Years 58 Months 5 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER George Tegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elenora Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Arthur E. Monninger

(Address) 800 E. North ave

15 Filed DEC 1 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Dec 8, 1929, that I last saw her alive on Dec 8th, 1929, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Harry L Hines, M. D.

12/10, 1929 (Address) 104 W. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Dec. 11 1929

20 UNDERTAKER: Mary A Gawthrop — ADDRESS: 2839 Gwynn Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51814

CERTIFICATE OF DEATH

88-002

E 51814

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St. 70-27 Ward 6

2-FULL NAME Joseph Cocnavilet

(a) RESIDENCE NO. 1811 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Mate	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dora Cocnavilet

6 DATE OF BIRTH (month, day, and year) March 19, 187

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	8	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Presser
(b) General nature of industry, business, or establishment in which employed (or employer) Of
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Dora Cocnavilet
(Address) 1811 W Mulberry St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of Skull
Struck by Street Car
at Baltimore & Gilmore St
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. O'Brooke, M. D.
Dec 10. 1929 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leader Hill — DATE OF BURIAL 12/11 1929

20 UNDERTAKER E. Eichlman & Son — ADDRESS 1028 Hanover St.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51815

CERTIFICATE OF DEATH

90 E 51815

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1621 N. Port St., 8-16 Ward)

2-FULL NAME Jonas B. Lehman

(a) RESIDENCE NO. 1621 N. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Margaret Lehman

6 DATE OF BIRTH (month, day, and year): Sept 26-1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	79	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany?

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany?

14 Informant: Johanna Etchberger
(Address): 1621 N. Port St

15 Filed 12/10/29 19 C. Humphreys Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis-Senile

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

19 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Fells Point Cem

DATE OF BURIAL: Dec. 11 1929

20 UNDERTAKER: George W. Jirkalen

ADDRESS: 1737 E. Eager St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Barnes

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51816

CERTIFICATE OF DEATH

89 ✓ E 51816

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2925 Ridgewood ave ST. 15-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary B Barnes

(a) RESIDENCE NO. 2925 Ridgewood ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced (or) WIFE of Millard F Barnes

6 DATE OF BIRTH (month, day, and year) Jan 15th 1861

7 AGE	Years	Months	Days 20	If LESS than 1 day, ...hrs. or....min.
✓	68	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Agnes Fishpaw

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Morris L Barnes
(Address) 2925 Ridgewood ave

15 Filed Dec 11 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1929

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1929, to December 8th, 1929, that I last saw h-e alive on December 7th, 1929 and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cardiac failure. Probably Coronary occlusion

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) Frederick V. Beetler, M. D.

Dec 9th 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lot Lincoln Cemetery Md

DATE OF BURIAL Dec 13th 1929

20 UNDERTAKER

ADDRESS

George Schilling & Sons N.S.C Monument St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51817

CERTIFICATE OF DEATH

E 51817

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Yates

(a) RESIDENCE NO. 8 S. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Yates

11 BIRTHPLACE OF FATHER (city or town) (State or country) La.

12 MAIDEN NAME OF MOTHER Josephine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Hospital Record

(Address)

15 Filed DEC 1 1929 C. HUMPHREYS JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-29

17 I HEREBY CERTIFY, That I attended deceased from 11-23, 1929, to 12-9, 1929

that I last saw h[illegible] alive on 12-9, 1929

and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Lymphatic edema of legs - ulceration of scalp

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

12-10, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	12/12 1929
20 UNDERTAKER	ADDRESS
Franklin W Seitz	704 W 33 St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51818

CERTIFICATE OF DEATH

X 100-001

E 51818

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 602 S. Linwood Ave. WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thanos Pologas

(a) RESIDENCE NO. 602 S. Linwood Ave. WARD Cumberland Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 2-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	1	2	9 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) " " Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

10 NAME OF FATHER Christ Pologas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Turkey

12 MAIDEN NAME OF MOTHER Ethel. Comnos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Turkey

14 Informant Christ Pologas

(Address) 602 S. Linwood Ave

15 Filed 11 1929 HERMAN JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 10, 1929, that I last saw h[illegible] alive on Dec 10, 1929 and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O. L. Long, M. D.

12/11, 1929 (Address) 2711 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	12/11 1929
20 UNDERTAKER	ADDRESS
William Gieskowich	18 Eastern

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51819

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 51819

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2304 Forest Park Ave. (WARD) 15-61

2—FULL NAME James N. Murphy

(a) RESIDENCE NO. 2304 Forest Park Ave. WARD 28th.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose E. Murphy

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	67	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER John P. Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Rose E. Murphy

(Address) 2304 Forest Park Ave.

15 Filed C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Dec 9, 1929, that I last saw h alive on Dec 8, 1929 and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis-
Myocarditis-

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 8 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W S Niblett, M. D.

12/9/29 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 13 1929.
20 UNDERTAKER John D. Denney	ADDRESS 715 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51820

CERTIFICATE OF DEATH

× 3 1 E 51820

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 642 N. Saratoga ST., 4-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Downs Donald Larkins

(a) RESIDENCE NO. 642 N. Saratoga ST., WARD 26.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Larkins

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 42 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ..

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ..

14 Informant: John Larkins

(Address): 642 N. Saratoga St.

15 Filed 1 1929 C. H. [illegible] JONES, C. ..

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/7/29

17 I HEREBY CERTIFY, That I attended deceased from 11/1, 19 29, to 12/7, 19 29, that I last saw h[illegible] alive on 12/7/29, 19 29 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. N. Haleter, M. D.

12/9, 19 29 (Address) 1 W Pr St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marshaw, N. Carolina

DATE OF BURIAL: Dec 11 1929

20 UNDERTAKER: Sam'l N. Chase & Son

ADDRESS: 1705 Mosher

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51821

CERTIFICATE OF DEATH

+19 E 51821

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew John Mai

(a) RESIDENCE NO. Oak Lawn Cem'y St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C Mai

6 DATE OF BIRTH (month, day, and year) Nov 28 - 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Caretaker
(b) General nature of industry, business, or establishment in which employed (or employer) Oak Lawn Cem'y
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Fred Mai

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Annie C. Mai
(Address) Oak Lawn Cem.

15 Filed ....., 19..... C. HAYDEN JONES, Registrar.

DEC 11 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull
Traumatic Shock - hit & knocked down by hit and run driver (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Casualty Md Gen Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Kraus, M. D.

12/10 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	Dec 12 1929
20 UNDERTAKER	ADDRESS
John H. Valentine	2326 Eden

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51822

CERTIFICATE OF DEATH

+19 E 51822

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St., 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Paul Mai

(a) RESIDENCE NO. Oak Lawn Cmty St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar 7-1920

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	9	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Aug. J. Mai

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Annie C Weatherly

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Annie C. Mai
(Address) Oak Lawn Cmty

Filed DEC 11 1929 H. [illegible] JONES, Registrar

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Struck by hit and run driver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern Av Rd & York Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Dame, M. D.

12/10 1929 (Address) 2939 W Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Mem

DATE OF BURIAL Dec 12 1929

20 UNDERTAKER John H. Valentine

ADDRESS 2326 Aiken Av

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51823

CERTIFICATE OF DEATH

74-001 E 51823

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 325 N. Ellwood Ave St., 6-11 Ward)

2-FULL NAME Anna Driver

(a) RESIDENCE NO. 325 N. Ellwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reinhold Driver

6 DATE OF BIRTH (month, day, and year) Dec 10/1844

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	84	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER XXXXXX Rauh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John Driver (son)
(Address) 325 N. Ellwood Ave

15 Filed 12/12 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Texas Ind Cemetery DATE OF BURIAL 12/12 1929

20 UNDERTAKER L. A. Inman ADDRESS 306 E Baltimore

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 51824 185 ✓ E 51824

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 3303 Ailsa Ave St. 27-44 Ward)

2-FULL NAME Cassandra H. Eigner

(a) RESIDENCE NO. 3303 Ailsa Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George W. Eigner

6 DATE OF BIRTH (month, day, and year) April 23/1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	42	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General naturo of industry, business, or establishment in which employed (or employer) 037
(c) Namo of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Andrew Mihn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Maykrantz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Geo. W. Eigner
(Address) 3303 Ailsa Ave

15 Filed C 11 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Dec 6/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism-Terminal Pneumonia
Accidentlt slipped in yard and
broke her leg Oct 9/29
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/10 192[illegible] (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 12/11 19 29

20 UNDERTAKER L. J. Horan

ADDRESS 3000 E Baltimore

Important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 51825

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51825

CERTIFICATE OF DEATH

17-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2103 W. Mulberry St (WARD) 20-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Ellard

(a) RESIDENCE NO. 2103 W. Mulberry St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Ellard

6 DATE OF BIRTH (month, day, and year) Nov. 2 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah V. Brown

(Address) 3614 Roslyn Place

15 Filed DEC 11 1929, 19 J. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/29.

17

I HEREBY CERTIFY, That I attended deceased from 9/30/, 1929, to 12/10/29, 19....., that I last saw h alive on 12/10/29, 19....., and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) ..... yrs. 9/30/29 mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? y Date of

Was there an autopsy? n

What test confirmed diagnosis? usual

(Signed) Edward J. Terry, M. D.

12/11/1929 (Address) 910 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral Cem

DATE OF BURIAL 12/13 1929

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E. Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51826

CERTIFICATE OF DEATH

118-002 E 51826

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Collington Ave. ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank J. Schumann

(a) RESIDENCE NO. 218 S Collington ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schumann

6 DATE OF BIRTH (month, day, and year) 22 Aug. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 31

(b) General nature of industry, business, or establishment in which employed (or employer) formerly machinist, steering

(c) Name of employer Dept. Bur. Steel Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ferdinan Schumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Anna Schumann (Address) 218 S Collington Ave Wife

15 Filed DEC 11 1929 H. M. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8th/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Dec 8, 1929, that I last saw h... alive on Dec 8, 1929 and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Volvulus of Colon)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cellulitis

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec. 10, 1929 (Address) 1314 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec. 12 1929
20 UNDERTAKER	ADDRESS
Tilly Zuber 111 C.	1038 N. Wolfe St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-991 E 51827

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 511 S. Madeira ST., V 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael T. Riesner

(a) RESIDENCE NO. 511 S. Madeira ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer Various Nurseries

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Christopher Riesner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Zorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa Riesner (Mother)

(Address) 511 S. Madeira St.

15 Filed DEC 1 1929 Registrar JONES

Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1929, to Dec. 9, 1929, that I last saw him alive on Dec. 9th, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lipsey, M. D.

19 (Address) 432 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec 13th 1929

20 UNDERTAKER Lilly & Sons Inc.

ADDRESS 400 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Bks.

Marnie Berry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51828 #6 E 51828

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1630 Barnes ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marnie Berry

(a) RESIDENCE NO. 1630 Barnes ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of James Berry

6 DATE OF BIRTH (month, day, and year) April 6, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	30	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Chas. Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto. city
(State or country)

12 MAIDEN NAME OF MOTHER Emma Purce

13 BIRTHPLACE OF MOTHER (city or town) Balto city
(State or country)

14 Informant James Berry
(Address) 1630 Barnes St

15 Filed DEC 1 1929, 19 C. HERMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Dec 8, 1929, that I last saw h alive on Dec 7 1929 and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) for

(duration) 0 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Johns Hopkins Records

(Signed) J. Edward Fisher, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec. 11 1929
20 UNDERTAKER Wm J. & Locke	ADDRESS 1302 Jeffers

Spec.—1-10-21—M&T—1500 Bks.

51829

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 51829

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hosp ST. 9-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. McDonald Jr.

(a) RESIDENCE NO. 605 N. Potomac WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lonia McDonald

6 DATE OF BIRTH (month, day, and year) April 18-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	57	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 073

(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Perryman Md

PARENTS

10 NAME OF FATHER Pat. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. O'Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Lorraine McDonald (Address) 605 N. Potomac St

15 Filed DEC 1 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1929 to Dec 9 1929.

that I last saw h[illegible] alive on Dec 9 1929.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Hundley, M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 12 29

20 UNDERTAKER Geo M. Fritz & Son — ADDRESS 811 N Wolfe

Cor.—10-10-29—A Co.—100 Bks.

L 51830

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51830

CERTIFICATE OF DEATH

REGISTERED NO. 188-103

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Butler

(a) RESIDENCE NO. 570 W Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Buler

6 DATE OF BIRTH (month, day, and year) June - 5 - 1884

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
43	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Butler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ida Butler Wife
(Address) 570 W. Lanvale

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
Hit & Knocked down by auto.
Secondary Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Lanvale St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visual

(Signed) ....., M. D.

Dec. 11 1927 (Address) 2939 Mc Elderry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec. 11 1927
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Argyle Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

36 ✓ E 51831

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. 11-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Howard

(a) RESIDENCE NO. 120 W. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Hutchins

6 DATE OF BIRTH (month, day, and year) ? 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓ 42 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Fred Gann

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Lucy Mabel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed DEC 11 1929 JOHN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-29

17

I HEREBY CERTIFY, That I attended deceased from 10-11, 1929, to 12-7, 1929, that I last saw her alive on 12-7, 1929 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Syphilis, tertiary

(duration) over 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Tacute

(duration) over 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.C.; Lab. Not

(Signed) Harvie M. McLean, M. D.

12-8, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec 12 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	725 Washington

Spec.—2-29-28—L. F. S.—500 Bks.

E 51332

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 51332

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Parker

(a) RESIDENCE NO. 1004 mc cullough ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. | 4 COLOR OR RACE: C. | 5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Parker

6 DATE OF BIRTH (month, day, and year): Nov. 15 1900

7 AGE: Years 29 | Months | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Edward Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rachel Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Anne Sheridan

(Address) 1004 Mc Cullough St

15 Filed DEC 11 1928 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9, 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1928, to Dec. 9, 1928, that I last saw him alive on Dec. 9, 1928, and that death occurred, on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Rest Cem.	Dec 12, 1928
UNDERTAKER	ADDRESS
Wm. R. A. Elliott	1725 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

E 51833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001
E 51833

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4502 Penhurst St. 28-63 Ward)

2-FULL NAME Laura J Figo.

(a) RESIDENCE NO. 4502 Penhurst St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Femb	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Saml J Figo

6 DATE OF BIRTH (month, day, and year) Dec 7-1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	71		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co
(State or country) Md

PARENTS

10 NAME OF FATHER Saml Harbaugh

11 BIRTHPLACE OF FATHER Washington Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ruhrwein

13 BIRTHPLACE OF MOTHER (city or town) Ned
(State or country)

14 Informant Mrs Rae Plumberg
(Address) 4502 Penhurst Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF Death

16 DATE OF DEATH (month, day, and year) Dec 10 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy (duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Fleckenstein, M. D.

Dec 10 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery Balto Co — DATE OF BURIAL Dec 12 19 29

20 UNDERTAKER Forsyth Sykes 160 W. Baltimore — ADDRESS

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51834 ✓ 90 E 51834

CERTIFICATE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 407 Ogsten St. 17-24 Ward)

2-FULL NAME Josephine Perkins

(a) RESIDENCE No. 407 Ogsten St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem'l	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Ont
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jerry Martin

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Lola Dobson
(Address) 418 N. Eutaw

15 Filed DEC 1 1929, 19.. H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Hedrick, M. D.

Dec 9th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist Columbia Cem — DATE OF BURIAL 12-12-1929

20 UNDERTAKER Daniel Cohen — ADDRESS 916 Pa Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51835

CERTIFICATE OF DEATH

3/ E 51835

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Bell

(a) RESIDENCE NO. 18 S. Spring st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Rayton Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 DEC 11 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1929, to Dec. 7, 1929, that I last saw him alive on Dec. 7, 1929, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Thrower Jr., M. D.

12-7, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL 12-11 1929

20 UNDERTAKER David Easter ADDRESS 916 Pa ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51836

CERTIFICATE OF DEATH.

10-001

10 E 51836

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkins Aves ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Esther Harris

(a) RESIDENCE NO. 1822 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Harris

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓ 32.	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John H Fantom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emma McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Esther Harris (Address) 1822 W. Saratoga St

15 Filed DEC 11 1929 J. M. JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-7, 1929, to 12-10, 1929, that I last saw h[illegible] alive on 12-10, 1929 and that death occurred, on the date stated above, at 5[illegible] 9 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 12/11 1929

20 UNDERTAKER Siegold Funeral Home ADDRESS Fayette

Spec.—1-10-21—M&T—1500 Blks.

E 51837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 51837

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oldham St.) (WARD) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Peregoy

(a) RESIDENCE NO. 661 Dunbar St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Peregoy

6 DATE OF BIRTH (month, day, and year) March 7th 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Peregoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Clementina Kephinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Mary M. Peregoy

(Address) 661 Dunbar St.

15 Filed DEC 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 1929.

17 I HEREBY CERTIFY, That I attended deceased from 12-5-29, 19... to 12-10-29, 19...

that I last saw h alive on 12-10-29, 19...

and that death occurred, on the date stated above, at 6:1 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W. B. Hendrix, M. D.

17 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govan's Presbyterian Cemetery — DATE OF BURIAL Dec. 13 1929

20 UNDERTAKER George L. Schwab — ADDRESS 201 Fremont Ave.

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—209 Bks.

51838

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

CERTIFICATE OF DEATH

E 51338

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. Howard & Madison St., 2069 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August J. Becker

(a) RESIDENCE NO. 17 Smallwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Becker

6 DATE OF BIRTH (month, day, and year) July. 14–1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 034

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Becker

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record (Address)

DEC 4 1929 H. JONES, Registrar

Filed RJK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Dec 8, 1929, that I last saw him alive on Dec 5, 1929, and that death occurred, on the date stated above, at 9 00 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Dec 7, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A. Weinstein, M. D.

12/8, 1929 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Dec. 11 1929

20 UNDERTAKER George L. Schmatt ADDRESS 201 Fulk. Ave.

very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 51839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 V E 51839

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Rupp St. WARD) 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Ridgfold

(Residence in Baltimore: No. 2108 Rupp St. St.; 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH, December 1 (Month) (Day) (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). England

PARENTS.

10-NAME OF FATHER. Harry Siegler

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Sarah Sosloden

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jr. Lewis

(Address) 1439 E Balto St

15- Dec 1 1929 H. G. JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11 (Month) (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1924, to Dec 11 1929, that I saw h[illegible] alive on Dec 10 1929, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Benjamin Pushkin M. D.

Dec 11, 1929 (Address) 1804 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rodale

DATE OF BURIAL. 12-11-, 1929

20-UNDERTAKER Jack Lewis, 1439 E Balto St

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 51840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51840

1-PLACE OF DEATH

City of Baltimore: (No. 512 S. Grove St.) 27-30 (Ward) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Campbell

(a) RESIDENCE NO. 512 S. Grove St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Campbell

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Benj. Campbell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Gough

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs S. Campbell
(Address) 512 S. Grove St

15 Filed Dec 11 1929 C. HAMILTON JONES, Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to Stab Wound of Heart & Lung.

Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zollyer M. D.

12/10 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary Co Md

DATE OF BURIAL Dec. 11, 1929

20 UNDERTAKER Mrs Katie R Williams

ADDRESS 322 N. Schroeder St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51841

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 51841

CERTIFICATE OF DEATH

1—PLACE OF DEATH U. S. Marine Hospital, Baltimore, Md. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Neill

(a) RESIDENCE NO. 1739 E. Pratt St., Baltimore, Md. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	65	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Barge Eugene Hooper

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Neill

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Furlong

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant U.S. Marine Hospital Records,
(Address) Baltimore, Maryland.

15 Filed ... 1929 C. H. WILSON JONES, M. D.
By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1929, to Dec. 10, 1929, that I last saw him alive on Dec. 10, 1929 and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart, mitral insufficiency.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, chronic

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) Ralph E. Porter, M. D.

, 19 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery	Dec 12, 1929
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler, Inc	126 E. Monument

Cor.—10-10-20—A.C.—100 Bks.

E 51842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51842

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp St. 17-26 (Ward)

2-FULL NAME Bernard Swanhood

(a) RESIDENCE NO. 761 W Franklin St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 1/2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race Col | 5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3 1910

7 AGE Years 14 | Months 11 | Days 3 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Swanhood

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Barnes

13 BIRTHPLACE OF MOTHER (city or town) Annapolis Md
(State or country)

14 Informant Jos Swanhood
(Address) Highland Beth Hosp

15 Filed ..... 19 ..... Registrar

1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

....., 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Moriah Cem | DATE OF BURIAL 12/12 1929

20 UNDERTAKER Sam'l Buckley | ADDRESS 5784 Biddle St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 51843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 OE 51843

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 871 N Franklin ST. 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucretia Thomas

(a) RESIDENCE NO. 871 N Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5/ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 18 78

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Minnie Watkins

(Address) 871 N Franklin

15 Filed DEC 11 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929, to Dec 10, 1929, that I last saw her alive on Dec 10, 1929 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank Gradwohl, M. D.

12/11, 1929 (Address) 1016 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Dec 11 1929

20 UNDERTAKER Samuel T Wensley

ADDRESS 57 Middle St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51844

CERTIFICATE OF DEATH.

X 14-001

E 51844

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. ..... St. 25-72 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Breichner

(a) RESIDENCE No. Emmitsburg, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 6 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Girl

(b) General nature of industry, business, or establishment in which employed (or employer) work at Hospital

(c) Name of employer Col Emmitsburg Md.

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER J. Brickner Sr.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Nettie Breichner.
(Address) Emmitsburg Md

15 Filed 11-1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 11 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-30, 1929, to 12-11, 1929.

that I last saw h[illegible] alive on 12-11, 1929

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George Breiner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. St. Mary's Cem. Emmitsburg, Md.	12/13 1929.

20 UNDERTAKER M. F. Rhuff Jr. ADDRESS Emmitsburg, Md.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51845

CERTIFICATE OF DEATH

E 51845
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 230 N. Gilmore St. 19-27 Ward)

2-FULL NAME Wm E. Carpenter

(a) RESIDENCE NO. 230 N. Gilmore St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/12/29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	✓	4 ✓	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country) " "

14 Informant Charles H. Alexander
(Address) 1416 Druid Hill Ave

15 Filed ....., 19.... Registrar

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Crowle M. D.

Dec 9. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Dec 11 1929
20 UNDERTAKER	ADDRESS
Charles H. Alexander	[illegible]

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51846 ✓ E 51846

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1504 Byrd ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J. Curley

(a) RESIDENCE NO. 1504 Byrd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Curley

7 DATE OF BIRTH (month, day, and year): Dec. 6. 1874

8 AGE: Years 55 | Months 0 | Days 24 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 050
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Balto., Md.

11 NAME OF FATHER: Thos. Curley

12 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

13 MAIDEN NAME OF MOTHER: Mary Moran

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

15 Informant: Mrs. Elizabeth Curley
(Address): 1504 Byrd St.

Filed C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 10/29

17 I HEREBY CERTIFY, That I attended deceased from 12. 1, 1928, to 12. 10, 1929

that I last saw him alive on 12 9, 1929

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

12;10, 19 29 (Address) 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Dec. 12 1929

20 UNDERTAKER: Margaret G. Flynn — ADDRESS: 1422 Light St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51847

CERTIFICATE OF DEATH.

90 E 51847

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 22 S. Highland Ave (St.) 26-2 (Ward)

2-FULL NAME Joseph M. Willdridge

(a) RESIDENCE NO. 22 S. Highland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Willdridge

6 DATE OF BIRTH (month, day, and year) July 5, 1859

7 AGE — Years 70 | Months 5 | Days 6 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter House & Decorator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Port Glasgow Scotland

PARENTS

10 NAME OF FATHER John Willdridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Glasgow Scotland

12 MAIDEN NAME OF MOTHER Martha Moir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Port Glasgow Scotland

14 Informant Mrs. Josephine Schleibaum (Address) 22 S. Highland Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1927, to Dec 11, 1927.

That I last saw him alive on Dec 10 1927

and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH was as follows:

Chronic interstitial

(duration) 20 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Michael M. D.

1927 (Address) 204 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Dec 13 1927

20 UNDERTAKER Philip Henry — ADDRESS 2046 Orleans St

TION IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51848

CERTIFICATE OF DEATH.

38 E 51848

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 6-10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Vollmer

(a) RESIDENCE NO. 417 N. Lakewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Anna Vollmer

6 DATE OF BIRTH (month, day, and year) Sept. 3/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	50	3	7	8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat butter

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ger.

PARENTS

10 NAME OF FATHER Vollmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Anna Vollmer (Address) 417 N. Lakewood Ave

15 Filed 1 1929 H. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1929. to Dec. 10, 1929.

that I last saw him alive on Dec. 10, 1929,

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Luetic Aortic Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann.

(Signed) M Weinstein M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 12/13 1929

20 UNDERTAKER Philip Herwig

ADDRESS 206 Orleans

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51849
1—PLACE OF DEATH

CERTIFICATE OF DEATH

90

E 51849

CITY OF BALTIMORE: (No. 5706 Richard Ave (ST.) 57-44 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul L. Eisenlohr

(a) RESIDENCE NO. 5706 Richard Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Eisenlohr

6 DATE OF BIRTH (month, day, and year) May 8-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brew. Master

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 yrs ago

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Vernon Eisenlohr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Emma Eisenlohr

(Address) 5706 Richard Ave

15 Filed DEC 11 1929 19 W. Ellis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 19 29 to Dec 9, 19 29, that I last saw h alive on Dec 9, 19 29 and that death occurred, on the date stated above, at 3:10 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl Brunst, M. D.

Dec 11 1929 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Dec 12 1929

20 UNDERTAKER John Meisel

ADDRESS 2008 Orleans

Spec.—8-16-29—L. F. S.—100 Bks.

E 51850

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51850

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 706 N Chester ST. 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W Forrester

(a) RESIDENCE NO. 706 N Chester ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Forrester

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street paver

(b) General nature of industry, business, or establishment in which employed (or employer): Balto City 040 retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Geo Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant Mrs Fannie Forrester

(Address) 706 N Chester St

Filed DEC 11 1929 19 H. M. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10-1929.

17

I HEREBY CERTIFY, That I attended deceased from 11-24, 19 29, to Dec 10, 19 29,

that I last saw h[illegible] alive on Dec 10 19 29

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Loos M. D.

12 11 19 29 (Address) 4 E N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Dec 13 19 29

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Orleans

Cor.—10-10-29—A Co.—100 Bks.

E 51851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 51851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St. 14-28 Ward)

2-FULL NAME Edith Pentz Pfieffer

(a) RESIDENCE NO. 1708 W. Lombard St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Pfieffer

6 DATE OF BIRTH (month, day, and year) ———

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
✓	53	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Pentz

11 BIRTHPLACE OF FATHER (city or town) Baltimor
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella T. Rose

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Agnes I. Crook
(Address) 4404 Carleview Road

15 Filed ... 19... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Coronary Thrombosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Crooke M. D.

Dec 11. 1929 (Address) 3601 3rd St. Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 12/12 1929

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 1105 W. Eutaw

DEC 11 1929 HINKLEY JONES

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 51852 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002 E 51852

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. 19-28 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Carey

(a) RESIDENCE NO. 421 S. Gilmor St St., Ward 17 M-Co

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-11-29

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Mass

12 MAIDEN NAME OF MOTHER Anna Louise Lanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Joseph Carey

(Address) 421 S. Gilmor

15 Filed 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-11, 1929, to 12-11, 1929

that I last saw her alive on 12-11, 1929

and that death occurred, on the date stated above, at 5.10 a m

The CAUSE OF DEATH* was as follows:

Prolapsed cord

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Emmons, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL Dec 3 1929

20 UNDERTAKER John J Fields

ADDRESS 120 N Fremont

Spec.—2-29-28—L. F. S.—500 Blks.

E 51853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51853

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Edna Perry

(a) RESIDENCE NO. 404 Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Clifford E. Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1-1-1929 G. HUNSON JONES M.D. Registrar

Dat 1201

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10-1929

17 I HEREBY CERTIFY, That I attended deceased from ..., 1929, to Dec 10, 1929, that I last saw h[er] alive on Dec 10, 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Meningococcus meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Meningococcus septicemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal fluid + blood culture

(Signed) J. W. Bickford Jr. M. D.

12/11, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	Dec 12 1929

20 UNDERTAKER Robert J. Williams ADDRESS 1515 McCulloh

Spec.—8-16-29—L. F. S.—100 Bks.

John D. Lupaiko

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51854

CERTIFICATE OF DEATH

101-901 ✓ E 51854

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S. Collington Ave ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John D. Lupaiko

(a) RESIDENCE NO. 406 S. Collington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth 22 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Lupaiko

6 DATE OF BIRTH (month, day, and year) Aug. 12/1884

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	3	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 59

(b) General nature of industry, business, or establishment in which employed (or employer) His Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Dominik Lupaiko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Elizabeth Lupaiko

(Address) 406 S. Collington Avenue

15 Filed ..., 19... [illegible] Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9/29

17 I HEREBY CERTIFY, That I attended deceased from 12/8, 1929, to 12/9, 1929, that I last saw him alive on 12/9, 1929, and that death occurred, on the date stated above, at 1410 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemorrhage of Intestines

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Jay A Ruttledge, M. D.

. 19 (Address) 1622 E Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart of Mary Cem.	Dec. 12 1929
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Ann St

Spec.—8-16-29—L. F. S.—100 Blks.

E 51855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 51855

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 506 S. Wolfe ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence J. Pawlak-or-WAWRZYNIEC

(a) RESIDENCE NO. 506 S. WOLFE Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Magdalena Pawlak

6 DATE OF BIRTH (month, day, and year) Aug, 10/1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	4	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe fitter

(b) General nature of industry, business, or establishment in which employed (or employer) 051

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Joseph Pawlak

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Marcianna Lejewska

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Magdalena Pawlak

(Address) 506 S. Wolfe Street

15 Filed 1-1029, 19 C. HERMAN JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10/29

17

I HEREBY CERTIFY, That I attended deceased from December 5, 1929, to December 10, 1929

that I last saw h[illegible] alive on December 8 1929

and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Hemorrhage (Rectal) result of growth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

12/11, 1929 (Address) 7579 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St, Stanislaus cemetery	Dec/14/1929 19
20 UNDERTAKER George A. Weber	ADDRESS 705 S Ann st.

Spec.—1-10-21—M&T—1500 Bks.

E 51856 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland ave. St. 7-4 100-00 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dolores Ziemba

(a) RESIDENCE NO. 504 S. Regester St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	3 mos	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Ziemba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Clara Cieka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Frank Ziemba (Address) 504 S. Regester st

15 Dec 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 19 29

17

I HEREBY CERTIFY, That I attended deceased from 10-23, 1929, to 12-10, 1929, that I last saw her alive on 12-10, 1929, and that death occurred, on the date stated above, at 2:55 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pyemia following Furunculosis

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Furunculosis (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 11-16-29

Was there an autopsy? Yes

What test confirmed diagnosis? History, Physical, Autopsy

(Signed) C. Hampson Jones, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Stanislaus Cem	Dec 11 1929
20 UNDERTAKER	ADDRESS
George A. Weber	705 S Ann St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51857 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51857

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-68

CITY OF BALTIMORE: (No. 2812 N. North Ave ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth E. Dorman.

(a) RESIDENCE NO. 2812 N. North Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tricomico Co. Md

PARENTS

10 NAME OF FATHER Matthais Dorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Gosley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter R. Giles

(Address) 5928 Falls Road

15 Filed 1-1-1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 10, 1929, that I last saw h... alive on Dec 9, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. R. Miller, M. D.

12/9/29 (Address) 2757 W. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec. 12 1929.
20 UNDERTAKER	ADDRESS
Horace F. Burgee	3631 Falls Road

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Knell 4207 Frederick Ave

E 51858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 129 E 51858

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2108 Wilkens Ave ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie A. Wright

(a) RESIDENCE NO. Philadelphia Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo L Wright

6 DATE OF BIRTH (month, day, and year) Dec 16 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50 50	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos J. Agnew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A Pulz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John M. Agnew

(Address) 2108 Wilkens Ave

15 Filed DEC 1 1929, 19 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Dec 10, 1929, that I last saw h[er] alive on Dec 10 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chr Lat. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phila Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. A Knell, M. D.

12/11, 1929 (Address) Irvington - Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 12/13/1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Thomson Hopkins Fulton 3-3

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51859

CERTIFICATE OF DEATH

129 E 51859

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5207 York Rd ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) (WARD) 37-46

2—FULL NAME Elizabeth A Lewis

(a) RESIDENCE NO. 5207 York Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Lewis

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Armeling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant John A Keagley

(Address) 5207 York Rd

15 DEC 1 1929 C. HUNTER JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 11 - 29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1929, to Dec 11, 1929, that I last saw h.e alive on Dec. 10, 1929 and that death occurred, on the date stated above, at 12.05a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) ✓ yrs. 5 mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) 5 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George L Thomson, M. D.

12/11, 1929 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 12-12 1929

20 UNDERTAKER H B Loh — ADDRESS 1217 Druid St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 51860

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 609-W-40½ ST., 13-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Adams

(a) RESIDENCE NO. 609-W-40½ ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 71 yrs. 9 mos. 28 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Adams

6 DATE OF BIRTH (month, day, and year) Feb 11 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Consulting Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Self 030

(c) Name of employer

9 BIRTHPLACE (city or town) Duisburg
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Adams

11 BIRTHPLACE OF FATHER (city or town) Duisburg
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ludwig

13 BIRTHPLACE OF MOTHER (city or town) Duisburg
(State or country) Germany

14 Informant Mr. Ernest H. Adams (son)
(Address) 609-W-40-St.

15 Filed DEC 10 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9-29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5 1929, to Dec 9 1929, that I last saw h.[illegible] alive on Dec 9. 1929 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephrocondetis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? — .

What test confirmed diagnosis? Clinical

(Signed) James C. Clarke, M. D.

Dec 10, 1929 (Address) Lafayette Apts. Charles & Read Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec-9/1929
20 UNDERTAKER	ADDRESS
Edward H. Mowen Company	108 W. Monroe

Spec.—2-29-28—L. F. S.—500 Bks.

E 51861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001 V E 51861

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Greenmount Ave ST., G-46 WARD)

2—FULL NAME John T McIntyre

(a) RESIDENCE NO. 2601 Greenmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Muth

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Toll

(Address) 2601 Greenmount Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

DEC 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 1929 to Dec 9 1929

that I last saw h alive on Dec 9 1929

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) La Grippe (duration) 1 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L A Richardson M. D.

Dec 10, 1929 (Address) 112 W. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Dec 12 1929

20 UNDERTAKER Mary M Redgrave

ADDRESS 201 E 22nd

Spec.—1-12-23—M&T—500 Blks.

E 51862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51862

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frances Gralewski

(a) RESIDENCE NO. 3615 Fairfield Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Gralewski

6 DATE OF BIRTH (month, day, and year): 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jan Stezepkawski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Michalina Budaa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14

Informant: Walter Gralewski

(Address): 3615 Fairfield Road

15

Filed 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 9 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to Dec. 9, 1929, that I last saw h alive on Dec 9, 1929 and that death occurred, on the date stated above, at 4·20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo-nephritis

Exophthalmic goitre

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) J. Kasdagna, M. D.

, 19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Brooklyn — DATE OF BURIAL: Dec. 12 19 29

20 UNDERTAKER: John M Wilder — ADDRESS: 401 N Charles St

THIS IS VERY important—See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Florence Jankiewicz

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 51863

CERTIFICATE OF DEATH.

152 E 51863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (St.) 7-4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Jankiewicz

(a) RESIDENCE NO. 1713 Eastern Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 22 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	11	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Jankiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Michalina Spioch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michalina Jankiewicz

(Address) 1713 Eastern Ave

15 12 1929 19 H. HAMPSON JONES, M. D. Registrar

Fee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/29 19

17

I HEREBY CERTIFY, That I attended deceased from 12/4/29 . 19 . to 12/10/29 . 19 ,

that I last saw her alive on 12/10/29 . 19 ,

and that death occurred, on the date stated above, at 2:45 A. m.

The CAUSE OF DEATH* was as follows:

carbuncle lip

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) septicemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/4/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Lundy, M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Dec. 14 1929

20 UNDERTAKER Felix M. Talbert & Sons ADDRESS Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51864

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Tuscany Apts., E-1 ST. 12-44 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daise Shryock Waxter

(a) RESIDENCE NO. Tuscany Apts., E-1 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Deal Waxter

6 DATE OF BIRTH (month, day, and year) May 27, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas J. Shryock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mariah Mann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant William Deal Waxter

(Address) Tuscany Apts., E.-1

15 Dec 11 1929 C. HUMSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17 I HEREBY CERTIFY, That I attended deceased from 1926, to 12-10, 1929, that I last saw h ER alive on 12-10, 1929, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

CHR. NEPHRITIS

(duration) 5+ yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John T. Dorsey, M. D.

. 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Dec. 12, 29 19

UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS

Mahlon B. Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

E 51865

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 51865

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 412 N. Duncan ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Fousek

(a) RESIDENCE NO. 412 N. Duncan ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frank Fousek

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czecho-slovakia

PARENTS

10 NAME OF FATHER Joseph Petrik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-slovakia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho-slovakia

14 Informant Frank Fousek

(Address) 412 N Duncan St

15 Filed DEC 11 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1927, to Dec. 10, 1929

that I last saw her alive on Dec. 10, 1929

and that death occurred, on the date stated above, at 8-20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Valvular Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Vaska, M. D.

, 19 (Address) 845 N. Wolfe Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 11 1929

20 UNDERTAKER Frank Brack Son — ADDRESS 1906 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

E 51866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00 E 51866

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Wenceslaus School St., 7-12 Ward)

2-FULL NAME Collington Ave nr Madison St
Sister Liberta Riha

(a) RESIDENCE NO. 814 N. Collington Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1-1870

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
59	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Milwauke, Wis.

PARENTS

10 NAME OF FATHER John Riha

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Josephine Cervenka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Sisters Notre Dame
(Address)

15 Filed 1 1 1929 19 C. HUMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Apoplexy

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. McCann, M. D.

12/1 1929 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Hd | DATE OF BURIAL Dec 12 1929

20 UNDERTAKER Paul Brack Sons | ADDRESS Catonsville

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51867

CERTIFICATE OF DEATH.

109-002 ✓ 109 E 51867

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4106 North Charles St. 12-49 Ward)

2-FULL NAME Mathilda S. Morrison.

(a) **RESIDENCE NO.** 4106 North Charles St. _____ **Ward** _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Theodore Morrison

6 DATE OF BIRTH (month, day, and year)
April 4th 1893

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
36	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.
(State or country)

PARENTS

10 NAME OF FATHER Mano Swartz

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Austria

12 MAIDEN NAME OF MOTHER Dena Saks

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Germany

14
Informant Milton Swartz.
(Address) 800 West North Ave.

15 Filed C. HARRISON JONES, M. D. Registrar
1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 19 29

17
I HEREBY CERTIFY, That I attended deceased from Sept 1927, to Dec 11th 1929, that I last saw h.. alive on Dec 11th 1929, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:
Streptococcus Staphylococcus
Pneumonia Bloodstream
Empyema. Following Bronchitis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Septicemia Empyema

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? Blood Culture

(Signed) C. Bloomhart, M. D.

, 19 (Address) 4 W N Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Friendship Cem	Dec 13/1929
20 UNDERTAKER J. Ahrens Co	ADDRESS 2432 Reisterstown Rd.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-E 51868

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Nichols (Nickel)

(a) RESIDENCE NO. 1700 Thames ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launch boat.

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 1 1 1929 C. HAMPSON JONES, M. D.

By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17 I HEREBY CERTIFY, That I attended deceased from 11-29-29, 19..., to 12-10-29, 19...,

that I last saw him alive on 12-10-29, 19...

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, acute & chronic

Delerium Tremens

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Vincents Angina

(duration) yrs. mos 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wass. P.C. Lab.

(Signed) Warren W. McClean, M. D.

12-11, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec. 16 1929

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Broadway.

Spec.—2-29-28—L. F. S.—500 Bks.

RAWE

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51869 ✓ E 51869

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Rawe

(a) RESIDENCE NO. 1509 Bank st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28, 1873 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Rawe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ernestine Neitsk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed 12 19 29 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 19 29, to Dec. 9, 19 29,

that I last saw him alive on Dec. 9, 19 29

and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thomas Jr. M. D.

12-10, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's 5th Rel. Church Cem. DATE OF BURIAL Dec. 12 19 29

UNDERTAKER Henry Sander & Sons, Inc. ADDRESS Baltimore St & Broadway

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51870

CERTIFICATE OF DEATH

1332 E 51870

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 848 S. Eutaw St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona Grimes

(a) RESIDENCE NO. 848 S. Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wesley Grimes

6 DATE OF BIRTH (month, day, and year): unk 1894

7 AGE: Years 35 Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md

PARENTS

10 NAME OF FATHER: Abraham Groves

11 BIRTHPLACE OF FATHER (City or town) (State or country): Calvert Co. Md

12 MAIDEN NAME OF MOTHER: Annie Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Md

14 Informant: Viola Howard

(Address) 848 S. Eutaw

15 Filed DEC 12 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 – 29 19

17 I HEREBY CERTIFY, That I attended deceased, from Nov 6, 1929 to Dec 10 – 29, 19, that I last saw h[illegible] alive on Dec 10, 1929, and that death occurred, on the date stated above, at 3 PM

The CAUSE OF DEATH* was as follows: Uremia Coma

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno R Boylston M. D.

19 (Address) 1502 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Dec 13 1929

20 UNDERTAKER: John H. Treadwell — ADDRESS 1027 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EC 12 1929

Spec.—8-16-29—L. F. S.—100 Bks.

Dillon

E 51871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 51871

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hosp ST. 12-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Patterson

(a) RESIDENCE NO. Southern Hosp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Patterson

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Leitel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Marcon Oliver

(Address) 4225 Harcourt Rd

15 Filed DEC 2 1929 H. M. ROBERTS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 1929 to Dec. 11 1929, that I last saw h[illegible] alive on Dec 10 1929 and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) one 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. C. Hoen, M. D.

12-11-1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Dec 13 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Baltimore St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51872

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodore Plater

(a) RESIDENCE NO. 220 Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56? or 65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Plater

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 12 1929, 19 [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8-29

17 12-28-28

I HEREBY CERTIFY, That I attended deceased from 12-28-28, 19..., to 12-8-29, 19...,

that I last saw h... alive on 12-8-29, 19...

and that death occurred, on the date stated above, at 10:30 PM m.

The CAUSE OF DEATH* was as follows:

1. Myocarditis, chronic & acute (duration) ...yrs. 10 mos. ...ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis (duration) ...yrs. 10 mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-22-29

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.E.

(Signed) Wm. H. Welch Steam, M. D.

12-10 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 12, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 3222 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51873 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51873

CERTIFICATE OF DEATH

57 V

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 901 E. 41st ST. 1-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elaine Buckheimer

(a) RESIDENCE NO. 901 E 41 St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 30, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Maurice Buckheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Ethel Beachum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. J. Maurice Buckheimer

(Address) 901 E. 41 St. Balto. Md.

15 Filed DEC 12 1929, 19 C. E. WILLIAM JONES (Registrar)

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to Dec. 10, 1929, that I last saw her alive on Dec. 10, 1929, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetic Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical Symptoms & Laboratory findings

What test confirmed diagnosis?

(Signed) Wm. H. Rumbaker, M. D.

19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec 1929

20 UNDERTAKER J. M. Fletcher Sons

ADDRESS North Ave

Cor.—10-10-29—A Co.—100 Bks.

Waryasz

E 51874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-09 E 51874

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 2-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Waryasz

(a) **RESIDENCE NO.** 609 S. Wolf St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8/1925

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	4	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Waryasz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Helen Jonczak

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant John Waryasz
(Address) 609 S. Wolfe St

15 Filed ... 19...

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to HER death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Both legs crushed by street car about 610 S. Wolf St.

Accidental-Inquest to be held Dec 12/29

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 11/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Haines, M. D.

12/12/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 13 1929

20 UNDERTAKER	ADDRESS
L. W. Ozazewski	1930 Eastern Ave

Important. See instructions on back of certificate.

C 12 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 51875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 51875

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ST 20-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Doll

(a) RESIDENCE NO. 154 Landsdeer Lane ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Doll.

6 DATE OF BIRTH (month, day, and year) May 29th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70?	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Baltimore ? Md

PARENTS

10 NAME OF FATHER Henry Doll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore ? Md

12 MAIDEN NAME OF MOTHER Anna Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany ?

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed 2 1929 BALTIMORE CITY HOSPITALS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17 I HEREBY CERTIFY, That I attended deceased from 12-7, 1929, to 12-10, 1929, that I last saw h~~im~~ alive on 12-10, 1929 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic Interstitial

(duration) yrs. over mos. 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) yrs. over mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Autopsy Lab

(Signed) Marvin M. McCleod, M. D.

12-10, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	12/13 1929
20 UNDERTAKER	ADDRESS
A. B. Wagner	1507 W Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

E 51876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Vol 100 E 51876

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3915 Woodlea ave St. 17-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo M Butler

(a) RESIDENCE NO. 3915 Woodlea ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 4 - 1908

7 AGE: Years 21 yrs 7 mos Months Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glazer

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: Ettenheimer Bros

9 BIRTHPLACE (city or town) (State or country): Balti Md

PARENTS

10 NAME OF FATHER: Thos W Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balti Md

12 MAIDEN NAME OF MOTHER: Laura E Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt

14 Informant: Laura E. Butler

(Address): 3915 Woodlea ave

Filed DEC 12 1929 T. HERBERT JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/1, 1929 to 12/11, 1929 that I last saw h[illegible] on 12/11, 1929 and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

11 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balt

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas E Eggleston M. D.

19 (Address) Cor Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec. 13 1929

UNDERTAKER: George W. Zinkler — ADDRESS: 1737 E. Eager St.

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51877

74-001 E 51877

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 905 Mc Henry St ST. 25-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick H. Snyder

(a) RESIDENCE NO. 2307 Sidney Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Snyder

6 DATE OF BIRTH (month, day, and year) April 17 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Swindell & Co.

9 BIRTHPLACE (city or town) (State or country) Connecticut

PARENTS

10 NAME OF FATHER George Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant Frank Snyder

(Address) 2305 Sidney Ave.

15 Filed 12 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Dec 10, 1929

that I last saw h[illegible]alive on Dec 10, 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. O. Campbell M. D.

Dec 12, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 12/13 1929

20 UNDERTAKER J. Few McCully

ADDRESS 130 E Fort

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51878

CERTIFICATE OF DEATH.

124 E 51878

1-PLACE OF DEATH 1618 Fulton St

CITY OF BALTIMORE, (No. 1618 Bolton St. WARD 14-20)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Amelia C. Blodgett

(Residence in Baltimore: No. 1618 Bolton St.; 11 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~UNMARRIED~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, April 26, 1837 (Month) (Day) (Year)

7-AGE, 92 yrs. 8 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Boston - Mass.

PARENTS.

10-NAME OF FATHER, Philip Cline

11-BIRTHPLACE OF FATHER (State or Country), Canada (French)

12-MAIDEN NAME OF MOTHER Amelia Clayton

13-BIRTHPLACE OF MOTHER (State or Country), Newfoundland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane B. Galt

(Address) 1816 Bolton St

15- DEC 12 1929 (Date) 1929 WILLIAM DEW, M. D. (Registrar)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1929 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 3 1929, to Dec 11 1929 that I saw h[illegible] alive on Dec 11 1929, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 8-10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5-6 yrs. mos. ds.

(Signed) William Dew M. D.

Dec 12, 1929 (Address) 2901 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, Dec 12, 1929

20-UNDERTAKER John B. Spence

ADDRESS 1325 N. Caroline St.

Cor.—10-10-29—A Co.—100 Bks.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51879

CERTIFICATE OF DEATH

89 ✓

E 51879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 424 N. Wolfe St. 6-9 Ward)

2-FULL NAME William Clark

(a) RESIDENCE NO. 424 N. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	53	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Jack Lewis
(Address) 1409 E Balto St

15 Filed ..... 19 ..... Registrar

12799

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) History of Stupor

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/11/29 (Address) 508 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odd Fellows Cem

DATE OF BURIAL 12/13 1929

20 UNDERTAKER Jack Lewis 1409 E Balto St

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 51880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51880

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1812 Linden St., 14-20 Ward)

2-FULL NAME Rosie Sigelman

(a) RESIDENCE NO. 1812 Linden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcus

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	83			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Wm Sigelman

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Feldman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Fanny Sigelman
(Address) 1812 Linden Ave

Filed DEC 12 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) H. C. Feldman, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Southern Ave. DATE OF BURIAL Dec 12, 29

20 UNDERTAKER Jack Lewis, 1431 ADDRESS E Balto St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

50

E 51831

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 11-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Webster

(a) RESIDENCE NO. 831 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Milton Gant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14

Informant Records of

(Address) Balto. City Hospitals

15

Filed 12 1929 SIMEON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17

I HEREBY CERTIFY, That I attended deceased from 11-25-29, 19..., to 12-10-29, 19...,

that I last saw her alive on 12-10-29, 19...

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Spinal Cord Tumor, Inflammatory

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 1, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Hotchkiss report

(Signed) Marvin M. McLean, M. D.

12-10-1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	12/13 1929
20 UNDERTAKER	ADDRESS
Samuel J. Hemsley	5781 Reisterstown

Spec.—1-12-28—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51882

CERTIFICATE OF DEATH.

E 51882

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 904 Aggle Ave ST. 17-24 (WARD)

2-FULL NAME James Lee

(a) **RESIDENCE NO.** 904 Aggle ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Lee

6 DATE OF BIRTH (month, day, and year): March 17-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: William Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary A. Lee

(Address): 904 Aggle ave

15 Filed DEC 12 1928 H. [illegible] Jones [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 1928

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1928, to Dec 10, 1928

that I last saw him alive on Dec 9, 1928

and that death occurred, on the date stated above, at 2.45 A. m

The CAUSE OF DEATH* was as follows:

Sarcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

12/11, 1928 (Signed) Frank Wagner, M. D.

(Address) 1076 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 12/12/1928

20 UNDERTAKER: Chas. H. Alexander — ADDRESS: 1406 Druid Hill

Spec.—1-10-21—M&T—1500 Bks.

E 51883 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 51883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST. 33 WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Wenger

(a) RESIDENCE NO. 1409 Covington St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Wenger

6 DATE OF BIRTH (month, day, and year) July [redacted] 1898

7 AGE	Years	Months	Days
	31	5	3

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Wenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Chas Wenger
(Address) 619 E Clement St

15 DEC 2 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929 to Dec 11, 1929. that I last saw him alive on Dec 11, 1929. and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) yrs. mos 17 da.
CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [redacted] M. D.
19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co

DATE OF BURIAL Dec 14, 1929

20 UNDERTAKER Margaret S Flynn

ADDRESS 1421 Eutaw Pl

ATION is very important. See instructions on back of certificates.

E 51884 Riley

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 51884

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1812 Thomas Ave ST: WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annette Riley

(Residence in Baltimore: No. 1813 Thomas Ave St.; 53 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: March 10, 1876 (Month) (Day) (Year)

7-AGE: 53 yrs. 9 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: Hamilton Jones

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Browning

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice S. Parkhurst

(Address) 1410 Park Ave

15

Filed C. HAMILTON JONES, M. D.

By REGISTRAR

2 1929

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 11th, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1929, to December 11th, 1929 that I saw her alive on December 11th, 1929. and that death occurred, on the date stated above, at 10 30 a.m. The CAUSE OF DEATH* was as follows:

Carcinoma of uterus, metastasis

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Alice S. Parkhurst M. D.

Dec 11, 1929 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 14, 1929

20-UNDERTAKER: Philip Henry — ADDRESS: 2019 Orleans St

BE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51885 49 E 51885

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mt Royal Ave & Calvert St. REGISTERED NO.

CITY OF BALTIMORE: (No. Int Royal Hotel ST., W 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Otho Eichelberger Ridgely

(a) RESIDENCE NO. Int Royal Hotel ST., 11th WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Henrietta Stuart Ridgely

6 DATE OF BIRTH (month, day, and year) January 30th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	10	11	
		1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Hampton
(State or country) Baltimore County

PARENTS

10 NAME OF FATHER Charles Ridgely

11 BIRTHPLACE OF FATHER (city or town) Hampton
(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Margaretta Sophia Howard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Otho Ridgely
(Address) Mt Royal & Int Hotel

15 12 1929 19 RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Dec 11, 1929, that I last saw h alive on Dec 11, 1929 and that death occurred, on the date stated above, at 11-30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm Rowe, M. D.

12-12 1929 (Address) St Paul & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Dec 13th 1929
20 UNDERTAKER Henry Jenkins & Son	ADDRESS Orchard & Eutaw Sts

Spec.—2-29-28—L. F. S.—500 Bks.

E 51386

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 51886

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp ST., (or) WARD)

REGISTERED NO. 12-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Rose Goodwin

(a) RESIDENCE NO. 2550 W Balto ST., St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
fem.	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Sept 5th 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas C Goodwin

(Address) 2550 W. Balto st

15 Filed 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1929, to Dec. 12, 1929, that I last saw h.[illegible] alive on Dec. 12, 1929 and that death occurred, on the date stated above, at 1 10 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Arthur Rattenni, M. D.

12/12, 1929 (Address) Franklin Sq Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	12/14/1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

E 51887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 E 51887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St. 1929 Ward)

2-FULL NAME Andrew J. Pearson

(a) RESIDENCE NO. 912 Ridgely St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Mal	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella Pearson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker. Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 003

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Ted Pearson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Thurmond

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Catherine Vernon
(Address) 646 Ogden St

15 Filed DEC 12 1929 G. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Broome, M. D.

, 19 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Dec 14 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51888

CERTIFICATE OF DEATH

90 E 51888

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4214 Kirkford Road (ST.) 12 50 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J. C. Williams

(a) RESIDENCE NO. Homewood Apts. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Martin Maddox

6 DATE OF BIRTH (month, day, and year): Aug. 7, 1851

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Judge (ret)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: Henry Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Priscilla E. Chew

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Richard C. Williams

(Address) 2023 N. Calvert St.

15 Filed: DEC 21 1929

C. F. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from ..., 1900, to 12/9, 1929, that I last saw the alive on 12/9, 1929, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Mitral & aortic insufficiency

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Break metastatic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. F. Thompson, M. D.

12/12 1929 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marks, Wash. Co. Md.

DATE OF BURIAL: Dec. 14 1929

20 UNDERTAKER: John O. Mitchell & Sons

ADDRESS: 1900 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51839

CERTIFICATE OF DEATH.

74-001 E 51839

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2504 N. Charles (Ward) 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Matthews.

(a) RESIDENCE NO. 2504 N. Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Matthews

6 DATE OF BIRTH (month, day, and year) Oct. 2nd 1857

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) Dorchester Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER John T. Matthews

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Charlotte Wingate

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dorchester Co. Md.

14 Informant Kate Matthews.

(Address) 2504 N. Charles St.

15 Filed Dec 13 1929 C. RAYMOND JONES, M. D. Registrar

Ref. 1000

Very Important. See Instructions on Back of Certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 19 1929

17

I HEREBY CERTIFY, That I attended deceased from ....., 19 27, to Dec. 10, 19 29, that I last saw him alive on Dec 10, 19 29, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) .....yrs. .....mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo M Forbes M. D.

Dec 12 19 29 (Address) 1135 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Dec 13 1929

20 UNDERTAKER Stephen Jones Sons ADDRESS 1214 N Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 51890

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 51390

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1250

CITY OF BALTIMORE: (No. 3127-N-Calvert ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Arndorf Rosenberger

(a) RESIDENCE NO. 3127-N-Calvert ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 67 yrs. 4 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: James A Rosenberger

6 DATE OF BIRTH (month, day, and year): Aug-7-1862

7 AGE: Years 67 | Months 4 | Days 3 4 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Savannah Georgia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown unknown

14 Informant: Harry K Rosenberger (Son)
(Address) 3127-N-Calvert St

15 Filed ....., 19.. [illegible] Registrar

13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-10-29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Dec. 11, 1929,

that I last saw her alive on Dec. 11, 1929

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Bronchitis

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation.

(duration) ....yrs. mos. 1-2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 13 1929
20 UNDERTAKER	ADDRESS
Stewart & Mooney Co	Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 51891

1—PLACE OF DEATH Mercy Hosp. REGISTERED NO. 28-71

CITY OF BALTIMORE: (No. 200 N Calvert ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James L Pessagno

(a) RESIDENCE NO. 501 Drury Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Pessagno

6 DATE OF BIRTH (month, day, and year) Jan 23rd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Pessagno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Pessagno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary T. Pessagno
(Address) 501 Drury Lane Ten Hills

15 Filed [illegible], 19 [illegible], Registrar

3 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 12-1929

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1929, to December 12, 1929, that I last saw h[illegible] alive on December 12, 1929 and that death occurred, on the date stated above, at 3 55 A m.

The CAUSE OF DEATH* was as follows:

Odema of lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ? yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Louise Neuhoff, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/14 1929

20 UNDERTAKER Chas R Gaud Son ADDRESS 11 S Mt Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-001
E 51892

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1324 Eutaw Place ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret M Smart

(a) RESIDENCE NO. 1324 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj C Smart.

6 DATE OF BIRTH (month, day, and year): Nov. 20, 1843

7 AGE: 86 Years | Months 8 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: David Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Virginia Lyford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: David C Smart

(Address): 5706 Berkley ave.

15 Filed DEC 13 1929, 19 H. JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 12. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 19 29, to Dec 12, 19 29

that I last saw h[illegible] alive on Dec 11th, 19 29

and that death occurred, on the date stated above, at 2.4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W E Dyer M. D.

12/12, 19 29 (Address) 720 N. Howard ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Dec 14 1929

20 UNDERTAKER: James B Ayres

ADDRESS: 1324 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

51893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. 51893

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 345 WARD)

2—FULL NAME Lewis Cohen

(a) RESIDENCE NO. 920 E. Pratt St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Cohen

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator on sewing machine

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0 & 0

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital

(Address)

15 Filed DEC 13 1929, 19 H. E. JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12th, 1929, to Dec. 12, 1929, that I last saw h[illegible] alive on Dec. 12, 1929 and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio Vascular Disease

(duration) 19 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Edema and Chronic Passive Congestion (duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Sacha F. Genglia, M. D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Union	12/13 19 29
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

E 51894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12 9 E 51894

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5007 Liberty Heights Ave ST. 26 (WARD) 6

2—FULL NAME Walter Olsan

(a) RESIDENCE NO. 5007 Liberty Hgts. Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indianapolis, Ind.

PARENTS

10 NAME OF FATHER Isidore Olsan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Rubin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E Balto. St.

15 Filed 6 13 1929 By H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12/29.

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929, to Dec. 12, 1929, that I last saw h[illegible] alive on Dec - 11 th, 1929 and that death occurred, on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Chronic pyorrhea,

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? All clinical tests

(Signed) Eugene Hoped, M. D.

19 (Address) 208 W Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cedar

DATE OF BURIAL 12-13- 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

√38 E 51895

1—PLACE OF DEATH √Baltimore City Hospitals

CITY OF BALTIMORE: (No. √Balto Mental ST. 11 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katie Brown

(a) RESIDENCE NO. 1031 Myrtle Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Brown

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE — Years: 62 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of Industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records

(Address) Balto City Hospitals

15 Filed: DEC 13 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-11-29

17 I HEREBY CERTIFY, That I attended deceased from 9-9-, 1927, to 12-11-, 1929, that I last saw [illegible] alive on 12-10-, 1929 and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

CONTRIBUTORY (Secondary) Lueten Infection (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Serological & Clinical

(Signed) [illegible] M. D.

12th, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side fot additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 12/13 1929

20 UNDERTAKER: James J Handley Sr — ADDRESS: 21 Biddle

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51896

CERTIFICATE OF DEATH

101-00 E 51896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. 11-24 St., Ward)

2-FULL NAME Clarence Davis

(a) RESIDENCE NO. 1219 Madison St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ns

6 DATE OF BIRTH (month, day and year) Apr 17 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
		7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Clarence Davis

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Jones

13 BIRTHPLACE OF MOTHER (city or town) N J
(State or country)

14 Informant Lillian Jones
(Address) 1219 Madison Ave

15 Filed 6 13 1929, 19.. H. LEMON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..yrs. ..mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical Recognition
(Signed) H. Lemon Jones, M. D.
6/13/29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 6/13/1929

20 UNDERTAKER Jno. Ged. A. Collard — ADDRESS 1618 Druid Hill Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

E 51397

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 51397

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 518 Forrestman ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily B. Thompson

(a) RESIDENCE NO. 518 Forrestman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. T. Thompson

6 DATE OF BIRTH (month, day, and year) Nov. 17-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	85	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. E. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Wm. [illegible] Thompson

(Address) [illegible]

15 Filed 13 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 '29

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Dec 10, 1929.

that I last saw h[illegible] alive on Dec 10, 1929

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinomata (peritoneal)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

12/13 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 12/13/29

20 UNDERTAKER Mrs. Geo. H. Collins

ADDRESS [illegible] Druid [illegible] 12-13-29

Spec.—2-29-28—L. F. S.—500 Bks.

E 51898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

33 ✓ E 51898

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 32-20

CITY OF BALTIMORE: (No. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Harris

(a) RESIDENCE NO. 538 Conway st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jim Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Liza Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1929, to Dec. 11, 1929, that I last saw her alive on Dec. 11, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Hamond M.D.

12-11, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem — DATE OF BURIAL 12-13 1929

20 UNDERTAKER Dennis Earley — ADDRESS 916 Ba ave

Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

E 51899 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 51899

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 18-26 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Preston

(a) RESIDENCE NO. 311 Arlington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie Boulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17 I HEREBY CERTIFY, That I attended deceased from 12-4, 1929, to 12-10, 1929 that I last saw h alive on 12-10, 1929 and that death occurred, on the date stated above, at 6 44 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Pumpkin, M. D.

12-11-1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-13 1929
20 UNDERTAKER David Eaton	ADDRESS 915 Oliver

Spec.—8-16-29—L. F. S.—100 Bks.

E 51909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51900

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 Park ave. ST., 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Donnell Foster

(a) RESIDENCE NO. 719 Park ave. ST., 11th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 6 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Foster

6 DATE OF BIRTH (month, day, and year) June 5 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William F. Frick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ann Eliz. Swan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Barton Jacobs

(Address) 11 nct. Vernon Pl. W.

15 Filed DEC 13 1929 C. HAMPSON JONES, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1929

17 I HEREBY CERTIFY That I attended deceased from Nov 1, 1929 to Dec 12, 1929, that I last saw h[er] alive on Dec 12 1929 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Nephritis & pulmonary oedema

CONTRIBUTORY (Secondary) chronic myocarditis (duration) yrs. 6 mos. ds.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. Warren Bucher M. D.

Dec 13 1929 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Dec 14th 1929

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS Mt Clayton & Orchard Sts.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51901 — 1-PLACE OF DEATH

CERTIFICATE OF DEATH.

143 E 51901

CITY OF BALTIMORE: (No. 121 W Osten St. 73-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henrietta A. Jackson

(a) RESIDENCE. No. 121 W Oslen St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: E Earl Jackson

6 DATE OF BIRTH (month, day, and year): May 20 1895

7 AGE: Years 34 Months 6 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Illing

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry C Franz

(Address) 112 Hollins ave

15 Filed DEC 13 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12/1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 12, 1929, that I last saw her alive on Dec 12, 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

abortion 2 months

non criminal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Curettage Dec 11 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Cushing M. D.

Dec 12, 1929 (Address) 3100 Hoffman Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk Cem. DATE OF BURIAL: Dec 14 1929

20 UNDERTAKER: Philip Henrig ADDRESS 2016 Eutaw St

HOW IS very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 51902

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51902

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 Sheridan Ave 97-48 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Brown.

(a) Residence No. 504 Sheridan Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W.

5-~~Single~~, Married, Widowed, ~~or Divorced.~~ (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Washington Brown

6-DATE OF BIRTH (month, day and year) Oct 5 1862

7-AGE, 67 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, Arthur Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Louisa Biggs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-

(Informant) Edward G Brown

(Address) 504 Sheridan Ave

15-

Filed DEC 13 1929

C. HAMPSON JONES, M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 12/29

17-I HEREBY CERTIFY, That I attended deceased from September 26 29 to December 12 29

that I last saw h~~e~~r alive on December 12 29,

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation.

Pulmonary Edema.

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Norman, M. D.

, 19 (Address) 4704 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Westminster Cemetery Md DATE OF BURIAL, Dec 14 29

20-UNDERTAKER, Kutzleb & Poe ADDRESS 1723 W Lafayette Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 51903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

gov E 51903

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3220 Carlisle Ave. ST. 15-61 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Earle Burke

(a) RESIDENCE NO. 3220 Carlisle Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	15	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public School

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edmond P. Burke

11 BIRTHPLACE OF FATHER (city or town) Princeton
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Emma L. Wattenscheidt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Christopher R. Wattenscheidt
(Address) 3220 Carlisle Ave.

15 Filed Dec 13 1929 H. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1929, to Dec 11, 1929, that I last saw him alive on Dec. 11, 1929 and that death occurred, on the date stated above, at 11.55 P.m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myocarditis
(Chronic)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno, M. D.

. 19 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec. 14 1929

20 UNDERTAKER Rosehill Co

ADDRESS 1003 W. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51904

CERTIFICATE OF DEATH

164 E 51904

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Haverhill Road ST. 25-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ellen Wirth

(a) RESIDENCE NO. 1023 Haverhill Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. dis. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	73	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wirth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalene Schwamm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Magdalene Miller
(Address) 1023 Haverhill Road

15 Filed DEC 13 1929 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11,1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 19 29, to Dec 11th, 19 29

that I last saw her alive on Dec 10th, 19 29

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Decay

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Bed

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Gerald Mortimer, M. D.

12/11/1929 (Address) 530 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

UNDERTAKER Ralph B Cook

DATE OF BURIAL Dec. 13 19 29

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51905

CERTIFICATE OF DEATH

90 ✓ E 51905

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., 816 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Allen

(a) RESIDENCE NO. 1819 N. Port ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late James Allen

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant Searles

(Address) BALTIMORE CITY HOSPITALS

16 Filed DEC 12 1929 19 G. H. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11-29

17 I HEREBY CERTIFY, That I attended deceased from 5-21-21, 19..., to 12-11, 1929, that I last saw her alive on 12-11, 1929 and that death occurred, on the date stated above, at 8-40 P. m.

The CAUSE OF DEATH* was as follows:

Hypocardilus, Chronic Jacute

(duration) over 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertrophic Bortitus over 8

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Ex.

(Signed) Warren W. McClean M. D.

12-12 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec. 14 1929
20 UNDERTAKER Henry Hoech Sons, Inc.	ADDRESS 1301 E Eager St

Spec.—8-16-29—L. F. S.—100 Bks.

E 51906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 E 51906

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 810 E Preston ST. 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Murphy

(a) RESIDENCE NO. 810 E. Preston ST.

(Usual place of abode)

Length of residence in city or town where death occurred about 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD

(If non-resident give town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann M. Murphy

6 DATE OF BIRTH (month, day, and year) 9th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
about.	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Ann M. Murphy (Address) 810 E. Preston St.

15 Filed DEC 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929 to Dec 1, 1929, that I last saw him alive on Dec 10, 1929 and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Central Hemorrhage (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

12/17/29 (Address) 700 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Dec. 14 1929

20 UNDERTAKER Henry Hoen & Sons, Inc. ADDRESS 1301 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 VE 51907

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., 90-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Catherine Fallon

(a) RESIDENCE NO. 1926 W. Franklin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper for

(b) General nature of industry, business, or establishment in which employed (or employer) Brothers

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Bernard J. Fallon

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine M Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14

Informant James Fallon

(Address) 1926 W. Franklin St

15

Filed DEC 3 1929, 19 ELLISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11/29

17

I HEREBY CERTIFY, That I attended deceased from 11/30/29, 1929, to 12/11, 1929.

that I last saw h alive on 12/11, 1929

and that death occurred, on the date stated above, at 4 or P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis.

(duration) yrs. 7 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Thos. E. Stacy, Jr. M. D.

19 (Address) Bon Secours Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 12/14 1929

20 UNDERTAKER H. Baumgardner

ADDRESS 1136 Baker. [illegible]

Cor.—10-10-29—A Co.—100 Bks.

E 32308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-02 51908

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 547 Burgundy alley 12-30 Ward)

2-FULL NAME Jacob R. Rice

(a) RESIDENCE NO. 547 Burgundy Alley Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mr Felix Brown
(Address) 608 S. Paca St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feley M. D.

12/11. 1929 (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemtery

DATE OF BURIAL 12/13 1929

20 UNDERTAKER Walter B. Spiga

ADDRESS 139 W. Hamburg St

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51909 HEALTH DEPARTMENT—CITY OF BALTIMORE A 51909

CERTIFICATE OF DEATH. 57 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2851 Pelham ave ST., 8 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Schoenagle

(a) RESIDENCE NO. 2851 Pelham ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Schoenagle

6 DATE OF BIRTH (month, day, and year) not known

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Oppitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Geo. Schoenagle

(Address) 4110 Garland

15 Filed DEC 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1929

17 I HEREBY CERTIFY, That I attended deceased from December, 1926, to December 11, 1929, that I last saw h alive on December 11, 1929, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diabetes

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Uremia etc

(Signed) Frank Jayd, M. D.

Dec 13, 1929 (Address) 2005 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Dec 14 1929

20 UNDERTAKER Gaul Brack Son ADDRESS 1906 Garland.

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51910

CERTIFICATE OF DEATH

100-001

E 51910

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Ellwood Ave (WARD) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Tamers

(a) RESIDENCE NO. 9 S. Ellwood Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Tamers

6 DATE OF BIRTH (month, day, and year) Dec 14th 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER Lewis Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant John W. Tamers

(Address) 9 S. Ellwood Ave

15 Filed 1 31 1929, 19 [illegible] Registrar.

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Dec 11, 1929, that I last saw h[illegible] alive on Dec 11, 1929 and that death occurred, on the date stated above, at 7.55 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & signs

(Signed) Adam C. Bareham, M. D.

12-12, 1929 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge

DATE OF BURIAL 12/14 1929

20 UNDERTAKER Williams Cook

ADDRESS 1217 St Paul

Spec.—2-29-28—L. P. S.—800 Blks.

E 51911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

25 E 51911

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Do. Balto. Gen. 2604 ST., 33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Hilda Gorsuch

(a) RESIDENCE NO. County Home Westminster Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30 yrs	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER Daniel Hassler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant H H Bankard & Son

(Address) Westminster Md.

15 Filed ..... 19.. Registrar

C 13 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12/29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 19 29, to Dec 12, 19 29, that I last saw h[illegible] alive on Dec. 12, 19 29, and that death occurred, on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Pancreatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephrolony & circulatory failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Westminster, Md.

Did an operation precede death? Yes Date of 12-11-29

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Edward A. Letsinger M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster — DATE OF BURIAL Dec 14 1929

20 UNDERTAKER H H Bankard & Son — ADDRESS Westminster

Spec.–7-17-26—A Co.—200 Bks.

51912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X57 E 51912

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

City of BALTIMORE: (No. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Bryant

(a) RESIDENCE NO. 614 Prince George St. Laurel Ward, Md

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. 4 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Allen P. Bryant

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1876

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
53	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER D. P. Chauncey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER E. Sherwood

13 BIRTHPLACE OF MOTHER (city or town) Washington

(State or country) D. C.

14 Informant Hospital Records

(Address) Laurel Md

15 Filed ..., 19... H. Hunter Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 d 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/9, 1929, to 12/13, 1929, that I last saw h[illegible] alive on 12/13, 1929, and that death occurred, on the date stated above, at 6 35 A. m.

The CAUSE OF DEATH* was as follows:

1). Diabetes mellitus

2). Acute bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) 1. C. V. D. disease & hypertension

2. chr. cholecystitis + cardio irregularity + congestion of liver

(duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Jno. A. Thompkins M. D.

12/13/29 (Address) Laurel Hosp

*State The Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Davy Hill Cemtery Date of Burial Dec 15th 1929

20 UNDERTAKER Elwood R. Fisher ADDRESS Laurel Md.

DEC 13 1929

Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 51913

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1842 Light ST. 23-34 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ada Linton

(a) RESIDENCE NO. 1842 Light ST.
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): July 31. 1881

7 AGE: Years 48 | Months 4 | Days 11 | If LESS than 1 day, hrs. or min. 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Woody

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Flora Stumph

13 BIRTHPLACE OF MOTHER (city or town) (State or country): germany

14 Informant: Wm. H. Linton
(Address) 1842 Light St.

15 Filed DEC 13 1929 [illegible] JONES, Registrar

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Linton

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 28. 1929 to Dec 11. 1929

that I last saw h[illegible] alive on Dec 11 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death? — (duration) yrs. mos. 1 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell M. D.

Dec 13. 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Dec. 15 1929

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Light St.

Cor.—10-10-29—A Co.—100 Bks.

E 51914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51914

X 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 9-17 Ward)

2-FULL NAME Joseph Lambert

(a) RESIDENCE NO. Avondale Road, Nr Tanner Vs St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Lambert

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Bettie Lambert
(Address) Avondale Road

15 Filed ..., 19.. C. HAMPSON JONES, M. D.
Registrar

DEC 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis & Nephritis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

12/11/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Dec 13 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland Ave

Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 51915

HEALTH DEPARTMENT—CITY OF BALTIMORE

Hebrew Aged Home

CERTIFICATE OF DEATH.

135 E 51915

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere & Greenspring ST. 27-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Perlmill

(a) RESIDENCE NO. Belvedere & Greenspring ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
91				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sigmund Feinblatt

(Address) Supt Hebrew Home for Aged

15 Filed DEC 13 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-13-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec-4-, 1929, to Dec-13-, 1929, that I last saw him alive on Dec-13-, 1929 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial-Insufficiency

about 3 yrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Urethral obstruction Prostatic-hypertrophy (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Herman Seidel M. D.

12/13 1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 12/13 1929

20 UNDERTAKER Jack Lewis 1929

ADDRESS E Balt St

FROM IS VERY important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 51916

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 W. Fairmount Ave (WARD) 26

2-FULL NAME Cordelia Hughes

(a) RESIDENCE NO. 707 W Fairmount ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hughes.

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	40	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER — Sammon

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Louise Smith

13 BIRTHPLACE OF MOTHER Maryland
(State or country)

14 Informant Charles Hughes
(Address) 707 W Fairmount

15 Filed 12 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11 1929

17

I HEREBY CERTIFY, That I attended deceased from 12/5, 1929, to 12/11, 1929.

that I last saw her alive on 12/10, 1929,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Coryza

Pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Dan'l Drummer M. D.

12/12 1929 (Address) 12 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary | DATE OF BURIAL Dec 15. 1929

UNDERTAKER R. L. Parham | ADDRESS 1007 N Howard St

TION is very important. See instructions on back of certificates.

E 51917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51917

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2131 Callow ave 13-54 St.; WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lozarus

(Residence in Baltimore: No. 2131 Callow ave St.; 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: (Month) (Day) (Year) (Sophia (wife))

7-AGE: 57 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Wholesale Grocery
(b) General nature of industry, business, or establishment in which employed (or employer): out

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: M. S. Lozarus

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Lewis

(Address) 1439 E Balto St

15

Filed DEC 13 1929, 191 [illegible] JONES, M. D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec - 13 - (Month) (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 10 -, 1929. to. Dec - 13 1929. that I saw him alive on Dec - 13 -, 1929. and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY): none

(Duration) yrs. mos. ds.

(Signed) Herman Seidel M. D.

Dec-13-, 1929 (Address) 2404 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Rehrem Memorial — DATE OF BURIAL: 12-13, 1929

20-UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51918

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

38 E 51918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St. 21-31 WARD)

2-FULL NAME Charles Miller

(a) RESIDENCE NO. 522 N. West ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) W I

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W I

14 Informant Hattie Banks

(Address) 524 N. West St

15 Filed DEC 13 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec 12, 1929, that I last saw h[illegible] alive on Dec 11, 1929, and that death occurred, on the date stated above, at 1215 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) yrs. 25 mos. ds.

CONTRIBUTORY (Secondary) Chronic Syphilis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Lab.

(Signed) M. Hendrix, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Dec 13 1929

UNDERTAKER J. L. Brown & Son

ADDRESS 1618 W. Mt'd

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51919

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 51919

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgie Stokes

(a) RESIDENCE NO. 527 Greenwillow ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Woodas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriet Steverson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed DEC 13 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10-29

17 I HEREBY CERTIFY, That I attended deceased from 4-3-29, 19..., to 12-10-29, 19..., that I last saw her alive on 12-10-29, 19..., and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) ... yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis over 1 (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home & Store

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: P.E.

(Signed) Harris M. McClean, M. D.

12-13, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-14 1929
UNDERTAKER Lewis A. Carter Undertaking Co	ADDRESS 916

Spec.—2-29-28—L. F. S.—500 Bks.

E 23 1928
E 51920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86-001

E 51920

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Bennett

(a) RESIDENCE NO. St. Inigoes P.O. Md ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alec Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 13 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-13-1929

17

I HEREBY CERTIFY, That I attended deceased from Dec-8, 1929, to Dec-13, 1929, that I last saw him alive on Dec 13, 1929, and that death occurred, on the date stated above, at 2:40 A m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Otitis media and mastoiditis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 12, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence C Gardner M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park M Mayfield

DATE OF BURIAL: Dec. 13 1929

20 UNDERTAKER: J. L. Robinson

ADDRESS: Dameron, Md.

Spec.—2-29-28—L. P. S.—500 Bks.

E 51921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 51921

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 2-4 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Chaney

(a) RESIDENCE NO. 2018 Eastern Ave. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown Dec 20 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	53 ?	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) ..... do

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed DEC 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11-29

17 I HEREBY CERTIFY, That I attended deceased from 12-8-29, 19..., to 12-11-29, 19...

that I last saw h... im alive on 12-11-29, 19...

and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Endocystema

..... (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fist. P.E. Lab

(Signed) Warren E. McLean, M. D.

12-11, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 16 1929
20 UNDERTAKER	ADDRESS
M. W. E. Ruppel	37 S Ann St

Spec.—2-29-28—L. F. S.—500 Blks.

E 51922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51922

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Clarmont Ave ST. 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Elizabeth Baer

(a) RESIDENCE NO. 3003 Clarmont Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 27, 1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
79	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Leonard Baer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Fox

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Wm. Baer
(Address) 1624 Druid Hill Ave

15 Filed 1 3 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 13, 1929, that I last saw h[er] alive on Dec 11, 1929 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration, Cardiac Hypertrophy, Arterio-Sclerosis, Chronic Interstitial Nephritis

some
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam & Laboratory

(Signed) A. F. Reis, M. D.

Dec 13, 1929 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 12/16, 1929

20 UNDERTAKER: Louis Heumann

ADDRESS: 32 S Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 51923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-002 51923

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1250 Sharp - 22-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME — Stump.

(a) RESIDENCE NO. 1750 Sharp. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				15 min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Stump

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balti.

12 MAIDEN NAME OF MOTHER Emma Long.

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant John Stump

(Address) 1250 Sharp St

15 Filed 13 1929 C. HAMPSON JONES, M. D. Registrar

3459

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 19 29 to Dec 11, 19 29, that I last saw h er alive on Dec 11, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth

seven months.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech Presentation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W White Jr, M. D.

, 19 (Address) 7800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER D. Commissioner Health.

ADDRESS DEC 13 1929

Rep. Wm. E. Woodall

Spec.—2-29-28—L. F. S.—500 Bks.

E 51924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51924

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5106 York Road (ST.) (47-48) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Owens Duncan

(a) RESIDENCE NO. 5106 York Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 17 ds. How long in U. S., if foreign birth? -- yrs. -- mos. - ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Edw. M. Duncan

6 DATE OF BIRTH (month, day, and year) Jan. 25, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin B. Owens

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna C. Harris

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Dr. Edw. M. Duncan
(Address) 5106 York Road

15 Filed 12 13 1929 O. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 9, 1929, to December 12, 1929, that I last saw her alive on December 12, 1929 and that death occurred, on the date stated above, at 1:35 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia,

(duration) ... yrs. ... mos. 3 days

CONTRIBUTORY (Secondary) ----------

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B. Jewett M. D.

. 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jessops Cemetery	12/14 19 29

20 UNDERTAKER Henry U. Mears & Son ADDRESS 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

(Czarnecka)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51925

CERTIFICATE OF DEATH

91-802

S 9264 E 51925

1-PLACE OF DEATH

City of Baltimore: (No.) 1007 S. Kenwood St. (Ward) 1-1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Czarnecka

(a) RESIDENCE NO. 1007 S Kenwood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	85			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant John Golembieski
(Address) 1007 S Kenwood Ave.

15 Filed ....., 19.... Registrar

1 3 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. G. Yates M. D.

(Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Standard Cem	Oct 14 1929
20 UNDERTAKER	ADDRESS
Alfred J. Falkowski Inc	1000 Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51926

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 E Baltimore ST. 26-39 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. King

(a) RESIDENCE NO. 3400 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert R. King

6 DATE OF BIRTH (month, day, and year): June 27/1867

7 AGE: Years 62 | Months 5 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George W. Rhea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Louisa Unjate

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: A. R. King

(Address) 3400 E. Baltimore St

15 Filed DEC 13 1929 C. HAMPSON JONES, M. D. Registrar

By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 12/1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929, to Dec. 12, 1929, that I last saw her alive on Dec. 12, 1929, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Embolism - cerebral

CONTRIBUTORY (Secondary) (duration) since Nov. 3rd yrs. mos. ds.

Endocarditis (duration) 2 or 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs & symptoms

(Signed) J. Thurwell M. D.

Dec. 13 1929 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Dec 14 1929

20 UNDERTAKER: Hughes Jones Inc — ADDRESS: 424 N Bond

Spec.—2-29-28—L. F. S.—500 Bks.

E 51927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51927

1—PLACE OF DEATH

REGISTERED NO. 8-12-31

CITY OF BALTIMORE: (No. 2601 E. Preston ST., 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Krapp

(a) RESIDENCE NO. 2601 E. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Barbara Krapp

6 DATE OF BIRTH (month, day, and year) July 17th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	43	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Iron 047

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Georg Krapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Cunnigunda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Barbara Krapp

(Address) 2601 E. Preston St

15

Filed 12-13-1929 C. HAMPSON JONES, M. D. Registrar

By ABH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12th 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1929 to Dec 12, 1929, that I last saw him alive on Dec 11, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings, X-ray

(Signed) Vincent Foster, M. D.

, 19 (Address) 845 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	12-16 1929
20 UNDERTAKER	ADDRESS
[illegible]	1217 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51028

1-PLACE OF DEATH

City of Baltimore: (No. ~~5011 E. 29~~ Mercy Hosp. St., 4-46 Ward)

REGISTERED NO. 51028

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Lehnert

(a) RESIDENCE NO. 5019 29th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Wid

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of ~~John~~ Lehnert

6 DATE OF BIRTH (month, day, and year) Nov. 19-1860

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	69		23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Char woman do
(b) General nature of industry, business, or establishment in which employed (or employer) Stewart Bld.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Lehnert

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. Jos. Stedman Jr.
(Address) 5216 29

15 Filed ....., 19.. C. HARRISON JONES, M. D. Registrar

OCT 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Grippe (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. T. Berry Coroner, M. D.

April 13 1929 (Address) 1629 Brenden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL April 14, 29

20 UNDERTAKER Wm. H. Valentine — ADDRESS 2326 Aisquith St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 V

E 51929

1-PLACE OF DEATH

City of Baltimore: (No. 580 Greenmillon Ave St.) (17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Jones

(a) RESIDENCE NO. 580 Greenmillon St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Nov 28-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Simon Jones

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Edna E Harris

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edna E Jones
(Address) 580 Greenmillon Ave

15 Filed 1929 G. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Th. H. Smith, M. D.
Dec 13th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12/14 1929
20 UNDERTAKER	ADDRESS
Saml. H. Chase & Son	1418 Mosher

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51930

CERTIFICATE OF DEATH

129 E 51930

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 10-19 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A Hoover

(a) RESIDENCE NO. 1001 Valley ST. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raymond Hoover

6 DATE OF BIRTH (month, day, and year): Aug. 29, 1883

7 AGE: Years 46 | Months 3 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Patrick Maguire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Mary Maguire

(Address) 1001 Valley St

15 Filed 1 3 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929, to Dec. 12, 1929

that I last saw h alive on Dec 12, 1929

and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Hypertensive heart disease

C Nephritis (chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 16, 1929
20 UNDERTAKER	ADDRESS
Edmund W. Conklin	924 E Eager St.

Spec.—2-29-28—L. F. S.—500 Blks.

2 8 1 9 6 4
E 51931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 66 ✓ E 51931

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Wallace Essick

(a) RESIDENCE NO. Reading Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn P. Essick

6 DATE OF BIRTH (month, day, and year) Mar. 15 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa -

PARENTS

10 NAME OF FATHER Wm Essick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Susan Rhoads

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa -

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 14 1929 C. HAMPSON JONES, M. D. Registrar By ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-13-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 13, 1929, that I last saw him alive on Dec 13, 1929 and that death occurred, on the date stated above, at X 03P m.

The CAUSE OF DEATH* was as follows:

alcoholism

(duration) yrs. mos. 3 weeks

CONTRIBUTORY (Secondary) —

— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Reading, Pa

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) Oskar Diethelm, M. D.

12. 13. 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reading Pa — DATE OF BURIAL Dec 14 1929

20 UNDERTAKER John O. Mitchell & Son. — ADDRESS 17.. Druid Hill Ave

Cor.—10-10-29—A Co.—100 Bks.

51932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 ✓ E 51932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 913 N. Eden St St., 10-13 Ward)

2-FULL NAME Joseph Wise

(a) RESIDENCE NO. 913 N. Eden St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of late Mary W. Wise

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	79			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant John Grier (Stepson)
(Address) 913 N. Eden St

15 Filed DEC 14 1929 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Myocardial Insufficiency

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Alcoholism
(duration) yrs. ? mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. H. Jones, M. D.
12/13/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 14 19 29
20 UNDERTAKER Henry Hauck & Son	ADDRESS 131 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1001

E 51933

1-PLACE OF DEATH 2793

City of Baltimore: (No. 2793 Wilkens Ave S. 26-72 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Illing

(a) RESIDENCE NO. Magothy River Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5 If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 12/1871

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
57	1	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shore
(b) General naturo of industry, business, or establishment in which employed (or employer) Caretaker
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Frank
(Address) Belinda Rd. Overlea

15 Filed ..., 19... C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke, M. D.

Dec 13 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon PK — DATE OF BURIAL Dec 14/29

20 UNDERTAKER Philip Henry — ADDRESS 2016 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-2t—M&T—1500 Bks.

E 51934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 51934

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hospital (WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred. Amelong

(a) RESIDENCE No. Fayette and Montford Ave (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Amelong

6 DATE OF BIRTH (month, day, and year): April 26-1866

7 AGE — Years: 63 — Months: 7 — Days: 17. — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: August Amelong

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Barbara Amelong

(Address) 2406 Orleans St.

15 Filed: 1 4 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 12, 1929, that I last saw h~~e~~ alive on Dec 11, 1929, and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Advanced Myocarditis

(Duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary Embolus

(Duration) 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) M H Hendrix, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Dec 14, 29

UNDERTAKER: Mrs C Dillon Son

ADDRESS: Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+129

E 51935

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse R. Simms

(a) RESIDENCE NO. Towson Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bloch & Decker Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lillie Corbit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John J. Simms

(Address) Providence Baltimore

Filed DEC 14 1929 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Dec. 13, 1929

that I last saw h— alive on Dec. 13, 1929

and that death occurred, on the date stated above, at 10.22 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with hypertension

2. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) W. H. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Providence Cem	Dec 16 1929
UNDERTAKER John Burns Sons.	ADDRESS Towson

Spec.—1-12-23—M&T—500 Blks.

E 51936

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51936

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 9-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ottilie Schaefer

(a) RESIDENCE NO. 447 Putnam Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Wt.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Nov 12-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	/	/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) N Y City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kolb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Perkins (Address) 447 Putnam Place

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

1 4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-9, 1929, to 12-13, 1929, that I last saw h[illegible] alive on 12-13, 1929 and that death occurred, on the date stated above, at 12.30 m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Dec 16 1929

20 UNDERTAKER ADDRESS

William Cook 1267 W Fayette

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr Pearce
Ed Counter Sign.
E 51937
74-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 E Preston ST., 9-16 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Della L Hunter

(a) RESIDENCE NO. 934 E Preston ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14. 1876

7 AGE — Years: 53 | Months: 0 | Days: 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Balt City Schools

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alexander Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McConley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Edith Patterson
(Address) 934 E Preston St

15 12 4 1929, 19 J. HARRISON JONES, M.D. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 13, 1929, that I last saw h alive on Dec 13, 1929 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Wm Pearce, M. D.

12/13, 1929 (Address) 1 St Paul St Hs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 12/16 1929

20 UNDERTAKER: W. Cook — ADDRESS: 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 51938

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 E 51938

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 801 Mc Kean Ave. ST. 16-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Emory Roland,

(a) RESIDENCE NO. 801 Mc Kean Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace M.Roland,

6 DATE OF BIRTH (month, day, and year) July 19.1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draughtsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.Government

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles E.Roland,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co.Md.

12 MAIDEN NAME OF MOTHER Eva Vandyke,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co.Md.

14 Informant Mrs.Grace M.Roland,

(Address) 801 Mc Kean Ave.

15 Filed DEC 4 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5th, 1929, to Dec. 12, 1929, that I last saw him alive on Dec. 12, 1929 and that death occurred, on the date stated above, at 6.45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza,

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maximilian Stark, M. D.

12,13,29 (Address) 806 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Dec 16 1929

20 UNDERTAKER Geo. H. Tittle

ADDRESS 2700 Edmondson ave

Important. See instructions on back of certificate.

Spec.—2-29-28.—L. F. S.—500 Blks. Selma E. Satterfield

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51939

CERTIFICATE OF DEATH

49 E 51939

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 E. Preston St. ST. 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Selma E. Satterfield

(a) RESIDENCE NO. 1749 E. Preston St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of LeRoy B. Satterfield

6 DATE OF BIRTH (month, day, and year) March 21, 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles B. Kearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Mahaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mr. LeRoy B. Satterfield

(Address) 1749 E. Preston St.

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12-29

17 I HEREBY CERTIFY, That I attended deceased from July 20 29, to 12-12-29

that I last saw h alive on 12-12-29

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edgar Lynch, M. D.

19 (Address) 800 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 16, 29

20 UNDERTAKER Harry N. Weitz & Co. ADDRESS 4101 Edmondson Ave.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51940

CERTIFICATE OF DEATH

1-V-004

E 51940

1-PLACE OF DEATH

City of Baltimore: (No. 3124 Harford Ave St., 9-45 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian A. Dantz

(a) RESIDENCE NO. 3124 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Barbara Dantz

6 DATE OF BIRTH (month, day, and year) June 24/1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	5 6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer) 056
(c) Name of employer Hanover Fire Ins. C

9 BIRTHPLACE (city or town) Palto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Christian Dantz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER E. Glorius

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Barbara Dantz
(Address) 3124 Harford Ave

15 Filed ....., 19.... C. Harrison Jones Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Monoxide Gas Poisoning - Overcome in garage at his residence.
Probably Accidental.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

12/14/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	12/14 1929
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

DEC 14 1929

Cor.—10-10-29—A Co.—100 Bks.

E 51941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 51941

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp St., Ward)

2-FULL NAME Louise Clipper

(a) RESIDENCE NO. 418 N. Bethel St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 29-1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	—	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer unknown

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Geo Clipper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant Emergency Hosp.
(Address)

15 Filed ..., 19 C. HAMILTON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
Fract Skull
Auto Truck in which she was riding overturned crushing her underneath (Hom) (duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Traumatic Shock
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Balto & Bond
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) L. Brance M. D.
12/9 1929 (Address) 3939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonny Cemetery

DATE OF BURIAL 12/11 1929

20 UNDERTAKER Ruth

ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 51942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 N. Fremont ST., 15-20 WARD)

2—FULL NAME Antonetta Grazziano

(a) RESIDENCE NO. 1332 N. Fremont ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Vincent Grazziano

6 DATE OF BIRTH (month, day, and year) DEC 8-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Tarsino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Grazziano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Josephine DeCola

(Address) Hanover Pa.

15 141929 19 C. HAMPSON JONES, D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26 1929, to Dec. 13 1929, that I last saw h~~er~~ alive on Dec. 13 1929 and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

, 19 (Address) 1663 N. Howard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	12/16 1929
UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 51943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) 15 (Ward) 64

REGISTERED NO. 1295

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Jacob A. Harris

(a) RESIDENCE NO. 3028 Brookfield Ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa Harris

6 DATE OF BIRTH (month, day, and year) May 15, 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min
78	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. A. Harris

(Address) New York

15 Filed 12 4 1929, 19 ... JAMES H. JONES, M. D. Registrar

TION is very important See instructions on back of certificate. Exact statement of OCCUPA-

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Dec 13, 1929, that I last saw him alive on Dec 13, 1929 and that death occurred, on the date stated above, at 11:30 p m

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis,

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. A. Alesi, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 12/15/1929

20 UNDERTAKER Morris Sondheim

ADDRESS 115-201 W. Mt Royal Ave

Spec.—2-29-28—L. F. S.—500 Blks.

(Kalus)

E 51944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 √ E 51947

1—PLACE OF DEATH

REGISTERED NO. 20-69

CITY OF BALTIMORE: (No. 2527 Christian ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophie V. Kalus

(a) RESIDENCE NO. 2527 Christian ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Kalus

6 DATE OF BIRTH (month, day, and year) Nov 15th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernest Riesen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Rudolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary C. Engel

(Address) 2527 Christian St.

15 Filed ..... 19..... Registrar

14192 ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, to Dec 11 1929.

that I last saw h.. alive on Dec 11 1929

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion
Pneumonia Both Lungs
Arteriosclerosis Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of Nov 30 - Mastoid Oper.

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Robert C Reed, M. D.

12/13 1929 (Address) 2107 W Mulberry ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 14th 1929
20 UNDERTAKER	ADDRESS
F. O. Wehrmann	1850 N. Gilmor St.

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 51945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 E 51945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Pressbury ST. 15-21 WARD)

2-FULL NAME Lavior Alton

(a) RESIDENCE No. 1614 Pressbury ST., WARD A. A. Co.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Joshua Alton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Coates.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Joshua Alton 1614 Pressbury St

15 DEC 14 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1929, to Dec 11th, 1929, that I last saw h[illegible] alive on Dec 11 1929 and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia "Bronchi"

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary T.B.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard L. French M. D.

12/12, 1929 (Address) 707 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 14 29
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 130 Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51946

CERTIFICATE OF DEATH

× 93 ✓

E 51946

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., H-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William D. Timmons

(a) RESIDENCE NO. Ocean City Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1875-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor B.R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) B.&O. R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Timmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Brittingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maple Timmons.

(Address) Wicomico Co.

15 12-14-1929 C. H. EMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-29

17

I HEREBY CERTIFY, That I attended deceased from 11-25-29 19 to 12-14 19 29

that I last saw h living alive on 12-14 19 29

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Rt. Saphenous Vein.

Varicose Veins Rt.

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12-2-29 Vein of Vein

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Luther C. Peter M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wicomico Co. Md.	12/14 1929
20 UNDERTAKER D. W. M. Coates	ADDRESS Salisbury Md.

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 51947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E. 51947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. Ann St. ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Wieprecht

(a) RESIDENCE NO. 232 S. Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework D 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Kawalska

(Address) 234 S. Ann St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 1929 to Dec 13 1929.

that I last saw h alive on Dec 13 1929

and that death occurred, on the date stated above, at 1155 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs

(Signed) J. L. Hooper M. D.

12/15 1929 (Address) 862 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Dec 17 1929

20 UNDERTAKER John M. Fiele ADDRESS 705 Chester St

DEC 14 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 51948

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51948

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Price

(a) RESIDENCE NO. 1130 Jenkins Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Grant Goldring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Briscoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed 14 1929 C. HUNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12-29

17

I HEREBY CERTIFY, That I attended deceased from 10-15, 1929, to 12-12, 1929, that I last saw h[illegible] alive on 12-12, 1929 and that death occurred, on the date stated above, at 5-50 P.m.

The CAUSE OF DEATH* was as follows:

Multiple Abscesses Left Lung;

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 1/2 hr

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 12-12-29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) L. U. Lumpkin, M. D.

12-13-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Maryland Cem. Baltimore

DATE OF BURIAL Dec. 16 1929

20 UNDERTAKER H. Lewis M. Johnson

ADDRESS 2325 Madison Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129-E 51949

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3503 Keswick Rd ST.) (13-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Kelbaugh.

(a) RESIDENCE NO. 3503 Keswick Road ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE (late) Ephriam Kelbaugh

6 DATE OF BIRTH (month, day, and year) July 30 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Human Kelbaugh

(Address) 3503 Keswick Road

15 Filed ..... 19 ..... C. HIMPSON JONES 19 .....
By ..... Registrar

C 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 19 29, to Dec 13, 19 29, that I last saw h[illegible] alive on Dec 17, 19 29, and that death occurred, on the date stated above, at 2.25 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

[illegible]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab & Typical Clinical

(Signed) T. H. Bosley M. D.

19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	Dec 19 19
20 UNDERTAKER	ADDRESS
Brenowitzon	[illegible]

IMPORTANT. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

E 51950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 E 51950

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) 13-51 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James D. Keller

(a) RESIDENCE NO. 3560 Poole St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Daisy Hilker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James Keller (father)

(Address) 3560 Poole St

15 Filed , 19 C. ATKINSON JONES, Registrar

C 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Dec 13, 1929, that I last saw him alive on Dec 13, 1929 and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis (Meningococcus)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Lumbar puncture

(Signed) Myron G. Zell, M. D.

12/13, 1929 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	Dec 16 1929
20 UNDERTAKER	ADDRESS
Edenwood	

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51951

CERTIFICATE OF DEATH

90 E 51951

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. 1015 Rectory Lane ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose B. Wess

(a) RESIDENCE NO. 1015 Rectory Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard B Wess

6 DATE OF BIRTH (month, day, and year) Oct 31, 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John J Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Malinda Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lillian Fisher

(Address) 1015 Rectory Lane

15 Filed DEC 14 1929 Geo. HAMPSON JONES, Registrar.

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1929

17

I HEREBY CERTIFY, That I attended deceased from June 1st, 1927, to Dec 12th, 1929, that I last saw her alive on Dec 11th, 1929, and that death occurred, on the date stated above, at 8 H. m.

The CAUSE OF DEATH* was as follows:

Myocarditis x Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jean Druery M. D.

12/14, 1929 (Address) 846 W 36 St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 16 1929
20 UNDERTAKER	ADDRESS
Johnson & Johnson	2445 Eutaw St

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 51952

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51952

CERTIFICATE OF DEATH.

90

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2214 Brookfield St.; 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Jacobson

(Residence in Baltimore: No. 2214 Brookfield St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 80 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Moses Jacobson

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. C. Kellerman

(Address) 2214 Brookfield Ave.

15-

Filed ....., 191.... Registrar.

C. HANSON JONES M. D.

DEC 14 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 13, 1929 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1929, to Dec. 13 1929, that I saw him alive on Dec 13 1929, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis old age

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Kellerman M. D.

Dec 14, 1929 (Address) 1515 N. Bentalou St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Portsmouth, Va.

DATE OF BURIAL, 12-17, 1929

20-UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 51953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51953

43

REGISTERED NO. 25-12

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Lee F Rother

(a) RESIDENCE NO. 647 Maury St Memphis Tenn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Rother

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Concrete Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 86

9 BIRTHPLACE (city or town) (State or country) La.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr Lee F Rother

(Address) 647 Maury Ave Memphis Tenn

15 Filed DEC 14 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-9 .1929. to 12-14 .1929.

that I last saw him alive on 12-14 .1929.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Mouth.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec-10-29

Was there an autopsy? no

What test confirmed diagnosis? Frozen section

(Signed) Ernest Spencer Jr. M. D.

.19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Memphis, Tenn

DATE OF BURIAL Dec 14 1929

20 UNDERTAKER Wm H Ricker Sons

ADDRESS Norfolk Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 14 1929

Cor.—12-9-25—A Co.—200 Bks.

E 51954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 51954

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3102 Kate Ave St. 15-58 Ward)

2-FULL NAME Anna P. Drimm

(a) RESIDENCE NO. 3828 Cottage Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. Drimm

6 DATE OF BIRTH (month, day, and year): Jan. 26 1901

7 AGE — Years: 28 Months: 10 Days: 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: The Hub.

9 BIRTHPLACE (city or town): Reisterstown Md.

(State or country)

PARENTS

10 NAME OF FATHER: Chas. K. Schaefer

11 BIRTHPLACE OF FATHER (city or town): Balto Co. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Clara J. Crouse

13 BIRTHPLACE OF MOTHER (city or town): Balto Co.

(State or country) Md.

14 Informant: Mr. Chas K. Schaefer

(Address) 3828 Cottage Ave.

15 Filed 1929 C. HUMPSON JONES, M. D. Registrar

Rec'd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. C. Smith M. D.

(Coroner)

Dec 13 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas Cem. Balto Co. Date of Burial: Dec 1929

20 UNDERTAKER: Wm. Huckner Sons ADDRESS: North Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

C 14 1929

Spec.—8-16-29—L. F. S.—100 Bks.

E 51955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11 2 E 51955

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 E. Fairmount ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris Rosenfeld

(a) RESIDENCE NO. 2023 E Fairmount ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) April 18 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Rosenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Riva Muskintrofsky

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Mary Rosenfeld

(Address) 2023 E Fairmount ave

15 Filed DEC 15 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 [illegible]

17

I HEREBY CERTIFY, That I attended deceased from November 30, 19 29, to Dec. 13, 19 29, that I last saw him alive on Dec. 13, 19 29, and that death occurred, on the date stated above, at 9 30 9 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ch. Isaacs, M. D.

12/14/1929 (Address) 314 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hooring Assn. | DATE OF BURIAL Dec 15 1929

20 UNDERTAKER Sol Levinson & Bro | ADDRESS 1127 E Baltimore St

DEC 15 1929

important. See instructions on back of certificates.

...ll be properly classified. Exact statement of OCCUPATION is very

Spec.—8-16-29—L. F. S.—100 Bks.

E 51956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 49

E 51956

1—PLACE OF DEATH U.S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Pierce

(a) RESIDENCE NO. 25 South St., New York City ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 18 ds. How long in U. S., if foreign birth? 9 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Burdell"

086

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER George T. Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records, U.S. Marine Hospital

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 13, 1929

17

I HEREBY CERTIFY, That I attended deceased from September 24, 1929, to December 13, 1929, that I last saw him alive on December 13, 1929, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of adrenal glands

(Hypernephroma)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Metastasis right femur, lungs kidneys

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? x-ray & postmortem findings

(Signed) [signature], M. D.

12/13, 1929 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bachmans Cemetery — DATE OF BURIAL 12/17/1929

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks. Raymond St Cuban House 1901 Eutaw Place Grad 5627

E 51957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 51957

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Elsinor Ave ST., 15-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine H. Flaherty

(a) RESIDENCE NO. 2005 Elsinor Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Flaherty

6 DATE OF BIRTH (month, day, and year) Feb 10, 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Capt Jas. A. Wharett

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Lucy Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Mary L. Hyland

(Address) 2005 Elsinor Ave

15 Filed DEC 15 1929, 19 JOHNSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13th 1929

17 I HEREBY CERTIFY That I attended deceased from Sept 10th 19 29 to Dec 13th 19 29

that I last saw h alive on Dec 11th 19 29

and that death occurred, on the date stated above, at 11:15 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Roentgenrays

(Signed) J B Silverhandle, M. D.

12/14 1929 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patricks Cemetery — DATE OF BURIAL 12/16/1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

Dr Brooks 3301 Brookly

E 51958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51958

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 415 Annabel Av ST. 25-15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas E Bruchey

(a) RESIDENCE NO. 415 Annabel Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabella Bruchey

6 DATE OF BIRTH (month, day, and year): Dec 13 1877

7 AGE: 52 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: car repair man

(b) General nature of industry, business, or establishment in which employed (or employer): B & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Isabella Bruchey

(Address) 415 Annabel Ave

15 Filed DEC 15 1929 WILLIAMSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to Dec 13, 1929, that I last saw h— alive on Dec 11, 1929 and that death occurred, on the date stated above, at 8 P— m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) St Louis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas D Brooke, M. D.

Dec 14 1929 (Address) 3601 3rd St. Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery | DATE OF BURIAL: 12-16-29

20 UNDERTAKER: W E Cook | ADDRESS: 1217 N Broad St.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eds.

E 51959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 9 E 51959

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3112 Barclay St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Ashby

(a) Residence No. 3112 Barclay St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H.

6-DATE OF BIRTH (month, day and year) March 12-1874

7-AGE. 55 yrs. 9 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Robert H. Ashby

(Address) 3112 Barclay St.

15- Filed, C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-13-1929

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1928 to Dec 13 1929.

that I last saw h.. alive on Dec 13 1929

and that death occurred, on the date stated above at 2:45 A m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

C/C Coroner / Attorney

Duration Yrs. Mos. Ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) Indefinite yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam and Op.

(Signed) Garland Ashcraft M. D.

Dec 14. 1929 (Address) 1534 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Auburn	12/16 1929
20-UNDERTAKER.	ADDRESS
Geo. Geo. H. Holland	1631 Druid Hill

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51960

CERTIFICATE OF DEATH

446 E 51960

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. WARD 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsie V Calp Calp

(a) RESIDENCE NO. 2951 Kennick Rd. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Frank Calp

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher Vogt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed DEC 15 1929, 19 [illegible] Registrar

C. P. [illegible] JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-29

17 I HEREBY CERTIFY, That I attended deceased from 11-14, 19 29 to 12-14, 19 29

that I last saw h alive on 12-14, 19 29

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia - following normal delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee Lumpkin, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 16 1929

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North Ave

It is important that this certificate be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 51961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1902 Loretta Ave ST. 10-17 WARD)

2-FULL NAME Susie Daniells

(a) RESIDENCE NO. 1902 Loretta av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Daniells

6 DATE OF BIRTH (month, day, and year) 2-10-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ...min.
	56	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Frank Carnage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Robert Daniells

(Address) 1902 Loretta Ave

15 Filed DEC 13 1929, 19 C. HAMILTON JONES, M. D. Registrar

Per ———

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12-1929

17 I HEREBY CERTIFY, That I attended deceased from 9-16-, 1929, to 12-12-, 1929, that I last saw h[illegible] alive on 12-12-, 1929, and that death occurred, on the date stated above, at 5.20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

History Personal knowledge

PRIMARY (duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George C Page M. D.

, 19 (Address) 1862 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion — DATE OF BURIAL Dec 16 1929

20 UNDERTAKER Joseph A Lively — ADDRESS 409 N Mount St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Blanks should be filled only typewriter. AGE should be stated EXACTLY. PHYSICIANS should SIGN

Spec.—2-29-28—L. F. S.—800 Blks.

E 51962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 51962

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3017 (Street) Frederick Ave (Ward) 20-72

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth I. Weaver

(a) RESIDENCE NO. 3017 (Usual place of abode) Frederick Ave ST., WARD

Length of residence in city or town where death occurred 8 yrs. 6 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Bell

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country) York

12 MAIDEN NAME OF MOTHER Rose M. Gallagher

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country) Illinois

14 Informant Wm Bell
(Address) Frederick Ave

15 Filed DEC 13 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Dec 13, 1929

that I last saw her alive on Dec 13, 1929

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy & effusion

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? aspiration Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy exam

(Signed) F F Kyser, M. D.

19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York, Pa

DATE OF BURIAL Dec 16 1929

UNDERTAKER F. B. Wyphut

ADDRESS 850 W. Baltimore

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51963

CERTIFICATE OF DEATH

111-001 ✓

E 51963

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3529 Gough ST. 26 WARD 37)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Schneemann

(a) RESIDENCE NO. 3529 Gough ST. 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schneemann

6 DATE OF BIRTH (month, day, and year) Jan. 24 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Schluderberg-Kurdle Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas H. Schneemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth Schneemann (Address) 3529 Gough St.

15 Filed ..... 19 ..... J. Nicholas Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13th/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1929 to Dec 10 1929, that I last saw him alive on Dec 10 1929 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

Myocardial Insufficiency

(Duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

Pulmonary Edema mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Wm G. Leyh, M. D.

19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Dec. 16 1929

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 4038 Woodland Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51964

CERTIFICATE OF DEATH

111-001 V

E 51964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 26-37 Ward)

2-FULL NAME James A. Mulkern (Sr)

(a) RESIDENCE NO. 455 S. 25th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs James Mulkern

6 DATE OF BIRTH (month, day, and year) Feb 20-1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James A. Mulkern

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McNulty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs James Mulkern
(Address) 455 S. 25th St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to ruptured Gastric Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

12/15, 1929. (Address) 2729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loc. Lawn Cem.	Dec 17, 29
20 UNDERTAKER	ADDRESS
Lilly & Fidelmo Inc.	433 W. Fayette

DEC 15 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 51965

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51965

CERTIFICATE OF DEATH

75-002 1867

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No.) 2207 Division ST. W-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Johnson

(a) RESIDENCE NO. 2207 Division ST. " WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Johnson

6 DATE OF BIRTH (month, day, and year) 7 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Union Stockyds

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eliza Jones

(Address) 2207 Division St.

15 Filed DEC 15 1929 HILLYER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 14, 1929, that I last saw h.. alive on " 14, 1929, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH was as follows:

Apoplexy

Hemiplegia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Old Age & Renal Disease

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Jos. Friedenwald M. D.

Dec 15, 1929 (Address) 1303 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 16 1929
UNDERTAKER	ADDRESS
Jerome E. Wright	1364 W. Cary

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 51966 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 9 E 51966

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 646 N. Bruce St., 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson

(a) Residence No. 646 N Bruce St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Johnson

6-DATE OF BIRTH (month, day and year) Mar 8, 1868

7-AGE, 61 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). 0/0

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jack Anderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Marie Daugherty

(Address) 1625 Harlem Ave.

15- Filed DEC 15 1929 WILLIAM H. JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-11-29

17- I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Dec 11, 1929, that I last saw her alive on Dec. 11, 1929, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cardiovascular-renal system Complications

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Lab.

(Signed) H. Maceo Williams, M. D.

12-11-1929 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Charlottesville Va	Dec. 15, 1929
20-UNDERTAKER	ADDRESS
Thomas E. Kelson	503 Freestman St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E. 51967 ✓ E. 51967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Gallagher

(a) RESIDENCE NO. 1112 S. Potomac ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank J. Gallagher Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	57 Unknown			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: John J. French Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: French Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14

Informant: Records of

(Address) Balto. City Hosp.

15

Filed DEC 19 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-13-29

17

I HEREBY CERTIFY, That I attended deceased from 12-9-29, 19..., to 12-13-29, 19...,

that I last saw her alive on 12-13-29, 19...

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic

Myocarditis, "

Hemorrhage into Cerebrum, suspected ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home & Hosp.

Did an operation precede death? No Date of —

Was there an autopsy? Cer. brain only 1/31

What test confirmed diagnosis? Hist. P.C. Lab

(Signed) Warren W. McCleave, M. D.

12-14, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	12/16 19 29
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Balto.

IMPORTANT. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

E 57968 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E-57968

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 28-6 ST. WARD)

2—FULL NAME Baby Girl Schwaab

(a) RESIDENCE NO. 4502 Wentworth Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-13-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Schwaab

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Baylis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md.

14 Informant Theo. Schwaab
(Address) 4502 Wentworth Ave

15 Filed DEC 15 1929 C. H. JONES, H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15-29

17 I HEREBY CERTIFY, That I attended deceased from 12-13, 1929, to 12-15, 1929, that I last saw her alive on 12-15, 1929 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

12/15, 1929 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 16 1929

20 UNDERTAKER Chas Wm. J. W. Zepp & Son — ADDRESS 501 W. Fayette

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E. 51969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001 E. 51969. E 51969

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Dalam ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian Lang

(a) RESIDENCE NO. 2508 Dalam ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth 36 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Mary Lang

6 DATE OF BIRTH (month, day, and year) Aug. 28 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Christian Lang Jr.
(Address) 802 Arlington Ave Gwyn

15 Filed DEC 15 1929 Registered No. 76604

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13/29

17 I HEREBY CERTIFY, That I attended deceased from Oct., 1929, to Dec. 13, 1929, that I last saw him alive on Dec 13, 1929 and that death occurred, on the date stated above, at 3089 m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senile debility & Prostatic trouble

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Visible

(Signed) B. B. Smith, M. D.

12/13, 1929 (Address) 1605 W. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec 16 1929
20 UNDERTAKER	ADDRESS
Joseph L. Fox	North

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51970 | 74-00 E. 51970 | L 549

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 211 Mallow Hill Rd. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David A. Hoffman

(a) RESIDENCE NO. 211 Mallow Hill Road. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht.	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ella R. Kolb Hoffman

6 DATE OF BIRTH (month, day, and year) Mch 4 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Small town store 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greagerstown Washington Co. Md.

PARENTS

10 NAME OF FATHER John N. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Jane E. Engler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Md.

14 Informant Mrs. Jos. McCurdy (Address) 211 Mallow Hill Rd.

15 Filed ..... 19 ..... W. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14/29

17 I HEREBY CERTIFY, That I attended deceased from Mch 4 1929, to Dec. 14 1929, that I last saw him alive on Dec. 13 1929 and that death occurred, on the date stated above, at 10.53 a. m.

The CAUSE OF DEATH* was as follows:

Failing Heart following Apoplexy & Pneumonia Mch 4/29. Gradual decline (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Trouble

(Signed) E. A. Forsyth, M. D.

12/14 1929 (Address) 1605 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Dec 17 1929
20 UNDERTAKER	ADDRESS
Jonah Syder	1600 N. North Ave

DEC 15 1929

IMPORTANT: DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 5-1971

E 5-1971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 5-1971

E 5-1971

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp St. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L. Lemmon.

(a) RESIDENCE NO. 1701 E. 32nd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances McGuire Lemmon.

6 DATE OF BIRTH (month, day, and year) March 29 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. 066

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Insurance.

(c) Name of employer Martin Barry.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John N. Lemmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburg, Pa.

12 MAIDEN NAME OF MOTHER Agnes Hanafin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bridgeport Conn.

14 Informant (Frances McGuire Lemmon, Wife) (Address) 1701 E. 32 St.

15 Filed C. H. THOMSON JONES, M. D. Registrar

C 1 51929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-12, 1929, to 12-14, 1929, that I last saw him alive on 12-13, 1929, and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes.

Did an operation precede death? yes. Date of 12-13-29

Was there an autopsy? yes. Necropsy.

What test confirmed diagnosis? yes.

(Signed) J. E. Lemmon M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL 12/17 1929

20 UNDERTAKER Mary M. Wiedefeld. ADDRESS 50 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51972 Towill

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51972 ✓

B 51972

B 51972

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital #130 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Towill

(a) RESIDENCE NO. Lenthicum Hgts ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2/ ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorena Hall.

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Mark Towill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Barrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Dr. R. Towill.

(Address) Lenthicum Heights.

15 Filed 5-1929 C. H. LINCOLN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 15, 1929, that I last saw h in alive on Dec 15th, 1929 and that death occurred, on the date stated above, at 3:23 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis, Right Femoral Artery

Gangrene Right leg

(duration) yrs. 1 mos. 7 ds. Prob.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History P.E. & Symptoms

(Signed) W. Glenn Fleischer M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wake Va.

DATE OF BURIAL 12/16, 1929

20 UNDERTAKER L. Vernon Lemmon

ADDRESS 4213 Park Heights Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51973

CERTIFICATE OF DEATH

REGISTERED NO. E 51973

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston Apt ST. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas H Skipper

(a) RESIDENCE NO. Preston Apts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie B. Skipper

6 DATE OF BIRTH (month, day, and year) Sept 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thomas Skipper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah E Grimmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Nannie B. Skipper

(Address) Preston Apts #1A

15 Filed ... 1929 ... H. C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/29

17 I HEREBY CERTIFY, That I attended deceased from May 29 1929, to December 14 1929, that I last saw him alive on December 14 1929, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration

(duration) Probably a year yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocardial Failure

(duration) Sudden yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Applicable

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Thomas Cradduck, M. D.

Dec 15. 1929 (Address) 1032 E. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clusterstown Md — DATE OF BURIAL Dec 17 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51974

CERTIFICATE OF DEATH

E 51974

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 810 Uhetta Ave (ST.) (WARD) 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nettie H. Jones

(a) RESIDENCE NO. 810 Uhetta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B. Jones

6 DATE OF BIRTH (month, day, and year): Jan. 25-1869

7 AGE: Years 60 | Months 10 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John H. Pittig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Birch Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John B. Jones

(Address) 810 Uhetta Ave

15 Filed 1929 JOHN H. JONES Registrar

DEC 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-14-29

17

I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1929, to Dec. 14, 1929, that I last saw her alive on Dec 14, 1929, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Uterine

Uterine Cancer

About 8 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. L. Nuckols, M. D.

19 (Address) 915 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrane Cemetery	12/17, 1929
20 UNDERTAKER: Williams Cook	ADDRESS: 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

✓ 46 Nuckols 730, 1915 Greenmount Ave - 6789

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51975

CERTIFICATE OF DEATH

117 ✓ E 51975

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD) 147

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Sadie L. Harrison

(a) RESIDENCE NO. 508 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 2

6 DATE OF BIRTH (month, day, and year) Oct. 21 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	✓	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Apartment House attendant

(b) General nature of industry, business, or establishment in which employed (or employer) 2

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER George Whedlee

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Mary Blount

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Self

(Address)

15 Filed DEC 16 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1929, to Dec 14, 1929

that I last saw h.e alive on Dec 14, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix with peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) paralytic ileus

(duration) yrs. mos. ✓ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec 12, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Nicholas Langconard, M. D.

12/14/1929 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyattsville Md — DATE OF BURIAL 12/16 1929

20 UNDERTAKER William Coop's — ADDRESS 1117 St Paul

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51976

CERTIFICATE OF DEATH

3/ V

51976

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Smith

(a) RESIDENCE NO. 941 Etting St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed DEC 13 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13-29

17 I HEREBY CERTIFY, That I attended deceased from 12-7-29, 19..., to 12-13-29, 19...,

that I last saw her alive on 12-13-29 19...

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

over

(duration) ... yrs. over mos. 35 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic ?

(cause) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Aut. & Lab

(Signed) Warren W. McLean, M. D.

12-14 19 29 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ave

DATE OF BURIAL 12-16 1929

20 UNDERTAKER Daniel Corbin

ADDRESS 946 E Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51977 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 51977

E 5197 CERTIFICATE OF DEATH 90 E 5197

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 11-21 St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabelle Cannon

(a) RESIDENCE NO. 1110 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hamstrong Pa.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Friend (Dead)
(Address)

15 Filed ..... 19.... Registrar

DEC 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1929, to Dec 14, 1929, that I last saw her alive on Dec. 14, 1929, and that death occurred, on the date stated above, at 3:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Jackson, M. D.

12/17/1929 (Address) 1000 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-16 1929
20 UNDERTAKER	ADDRESS
Daniel Coates	Penna

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51978

90 E 51978

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. ●

CITY OF BALTIMORE: (No. 425 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Manuel Harris

(a) RESIDENCE NO. 416 N. Myson St. (Fulton ave) ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER ? Harris

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Records of
(Address) B.C.H.

15 Filed DEC 16 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13-29

17 I HEREBY CERTIFY, That I attended deceased from 12-11-29, 19..., to 12-13-29, 19..., that I last saw him alive on 12-13-29, 19..., and that death occurred, on the date stated above, at 2:20 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? List PE

(Signed) Harris H. McLean, M. D.

12-14, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-16 1929
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

IMPORTANT—Should be carefully supplied. NOTE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Paul Rossmark

E 51979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 ✓ E 51979

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. ST. Joseph Hospital St. 26-42 Ward)

2-FULL NAME Paul Rossmark

(a) **RESIDENCE NO.** Cor. Hamilton & Valiquet (Ritter) Aves. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred] yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1/1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
✓	31	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) 013
(c) Name of employer

9 BIRTHPLACE (city or town) Thungen,
(State or country) Germany

PARENTS

10 NAME OF FATHER Konrad Rossmark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Papers of Deceased
(Address)

15 Filed DEC 16 1929 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot Rt Temple -Suicide

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Carr, M. D.

12/14/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemtery — DATE OF BURIAL Dec 16 1929

20 UNDERTAKER Lynch - J. Ruth — ADDRESS 1735 Eastern Ave

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51980 HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

CERTIFICATE OF DEATH

E 51980

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 3-4 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Dyiler Or DAIKO OR DAKIO

(a) RESIDENCE NO. 1513 Eastern Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russie

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Records of
(Address) Balto. City Hospitals
1513 Eastern Ave. F. Dashner

15 Filed ..., 19... Registrar

DEC 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13-29

17

I HEREBY CERTIFY, That I attended deceased from 6-25-29, 19..., to 12-13-29, 19...,
that I last saw him alive on 12-13-29, 19...
and that death occurred, on the date stated above, at 8:40 A m.

The CAUSE OF DEATH* was as follows:

Leukemia, chronic lymphoid

(duration) over 18 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia, Cardiac

(duration) over 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. PE. Lab. Xray Autopsy

(Signed) Warren H. McLean, M. D.

12-14, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independent	Dec. 16, 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas 2423	S PACA ST.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 51981

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1228 E. Monument St., 10-14 Ward)

2-FULL NAME Arthur Conrad Greenridge

(a) RESIDENCE NO. 1228 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Greenridge

6 DATE OF BIRTH (month, day, and year) Aug 5/1888

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
✓	41	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) Georgetown,
(State or country) Brittish So. Am.

PARENTS

10 NAME OF FATHER Joseph Greenridge

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Barbadoes, Br. W.I.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Demarara, S.A.

14 Informant Minnie Greenridge
(Address) 1228 E. Monument St

15 Filed DEC 16 1929 T. Lawson Jones, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aneurism Abd Aorta

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Sept/1929

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/10/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	12/18 1929
20 UNDERTAKER Clive H. Johnson	ADDRESS 416 N. Collington Ave

Spec.—2-29-28—L. F. S.—500 Bks.

23 E 51982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 51982

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander W Habershaw

(a) RESIDENCE NO. 1004 W 38th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Canned Foods Broker

(b) General nature of industry, business, or establishment in which employed (or employer) unknown 045

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alex W.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Jessie Steele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19.. C. JAMES PEARSON, M. D. Registrar

C 6 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15-29

17 I HEREBY CERTIFY, That I attended deceased from 12-11-, 1929, to 12-15-, 1929, that I last saw him alive on 12-15-, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Hypertension - Cerebro Vascular Disease

Duration Yrs. Mos. Ds.

Chronic nephritis

Duration Yrs. Mos. Ds.

Dilatation of Heart - Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia - Convulsions - Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. McSherry Smith, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md

DATE OF BURIAL Dec 16 1929

20 UNDERTAKER B L Hopkins

ADDRESS Annapolis Md

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 51983

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 2434 Guilford Ave., St. 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence E. Hoshall,

(a) RESIDENCE NO. 2434 Guilford Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rebecca S. Hoshall

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Pennsylvania Railroad

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Melchor Hoshall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth E. Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs Clarence Hoshall
(Address) 2434 Guilford Ave.

15 Filed DEC 16 1929, 19 LAWSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Hopkins, M. D.

12/16, 1929 (Address) 3622 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec. 16, 1929

20 UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51984

CERTIFICATE OF DEATH

168 ✓ E 51984

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. N.E.Dist Police Station St., 9-46 Ward)

2-FULL NAME William B. Berry

(a) RESIDENCE NO. 1157 Gorsuch Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) July 8, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	26	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Any One

9 BIRTHPLACE (city or town) Charles County
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Berry

11 BIRTHPLACE OF FATHER (city or town) Charles Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Pearson

13 BIRTHPLACE OF MOTHER (city or town) Charles Co.
(State or country) Md.

14 Informant Henry Berry
(Address) 1157 Gorsuch Ave.

15 Filed DEC 16 1929 WINFIELD JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.14 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation- hung himself with belt to cell door.

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Covell, M. D.

2/15/29 (Address) 303 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec 16/29
20 UNDERTAKER William Cook	ADDRESS 1217 St.Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 51985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 51985

REGISTERED NO. 6563

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2519 Garrison Blvd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Newton Cranwell

(a) RESIDENCE NO. 3815 Chatham Rd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Shaw Cranwell

6 DATE OF BIRTH (month, day, and year) July 29 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	64	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Continental Can Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. W. Cranwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Leesburg Va

12 MAIDEN NAME OF MOTHER Clara Bell Zerger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harpers Ferry W Va

14 Informant Mrs Annie D. Cranwell

(Address) 3815 Chatham Rd

15 Filed DEC 16 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Dec 13, 1929, that I last saw him alive on Dec 13, 1929, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Asthma (Chronic)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W S Dublet, M. D.

Dec 10/29 19 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Dec 16 1929

20 UNDERTAKER W. Tuckerer & Sons ADDRESS North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Maton

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51986

CERTIFICATE OF DEATH

47 ✓ E 51986

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 912 Fulton Ave St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Maton

(a) RESIDENCE NO. 912½ Fulton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ~~mos.~~ ~~ds.~~ (If non-resident give city or town and State)

How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Maton

6 DATE OF BIRTH (month, day, and year): Oct. 8 1867

7 AGE: ✓ Years: 62 Months: 2. Days: 5 IF LESS than 1 day hrs. or — min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self.

9 BIRTHPLACE (city or town)

(State or country): Baltimore City Md.

PARENTS

10 NAME OF FATHER: Samuel Dorsey.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mrs Berta Will

(Address) 912 N. Fulton Ave.

15 Filed DEC 16 1929 C. H. WILLIS, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1928, to Dec 13, 1929, that I last saw her alive on Dec 12, 1929, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of R. Breast.

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 1 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of June 20 - 28

Was there an autopsy? No

What test confirmed diagnosis? Usual methods

(Signed) Geo. C. Shannon, M. D.

12/13 1929 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

Date of Burial: Dec. 16, 1929

20 UNDERTAKER: Robt L. Turner

ADDRESS 1442 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51987

CERTIFICATE OF DEATH

E 51987

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST., 16-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilbert Hines

(a) RESIDENCE NO. 1011 Lafayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20 1928

7 AGE: Years 1 | Months 6 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Clarence Hines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Violet Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clarence Hines

(Address) 1011 Lafayette Ave

15 Filed 12-15-1929 Wilson Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1929, to Dec 14, 1929, that I last saw h- alive on Dec 14, 1929, and that death occurred, on the date stated above, at 2 00 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Terminal)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. 29 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benjamin Adams, M. D.

12/14, 1929 (Address) 8 Windsor Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery | DATE OF BURIAL: Dec 16 1929

20 UNDERTAKER: Samuel H. Wensley | ADDRESS: McCulloh

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51988

CERTIFICATE OF DEATH.

185 E 51988

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Franklin Square Hospital 16-6 C Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredericka W. Brucksch

(a) RESIDENCE NO. 1227 Poplar Grove St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leopold L. Brucksch

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
✓	77	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bermany

PARENTS

10 NAME OF FATHER Wilhelm Schulz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Richard Brucksch

(Address) 1227 Poplar Grove St.

Filed DEC 16 1929 C. H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident. Fall breaking L. R. Leg & left arm at her home—

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

(Signed) Chas. H. Brooke M. D.

(Coroner)

Dec 14 1929 (Address) 3601 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Dec 16 1929

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51989

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51989

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME John Eckman

(a) RESIDENCE NO. Mayfield, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Bell Eckman

6 DATE OF BIRTH (month, day, and year) March 12-1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	53	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car Repairing
(b) General nature of industry, business, or establishment in which employed (or employer) for W.B.&A.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Daniel Eckman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret McNamara

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Dora Eckman
(Address) Mayfield, Md.

15 Filed 19 [illegible] Registrar

DEC 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find, that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushing injury of Chest, Evulsion of Peritoneum - Multiple fractures of Pelvis Accidental Death
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Academy Junction

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feltz, M. D.

12-16. 1929. (Address) 2734 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 17 1929
20 UNDERTAKER	ADDRESS
John F Denny	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 51990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 51990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-38 WARD)

2-FULL NAME Alexander Snyder

(a) RESIDENCE NO. 3539 Pk Heights Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Mort Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mort Snyder

(Address) 3539 Pk Heights Ave

15 Filed DEC 15 1929 C. H. WILLIAMSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-7, 1929, to 12-15, 1929.

that I last saw him alive on 12-15, 1929

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Abc.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

12/15, 1929 (Signed) Samuel J. Hankin M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int. Cem. DATE OF BURIAL 12/16 1929

20 UNDERTAKER Jack Lewis 1439 ADDRESS Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51991

E 51991

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Carrollton Ave ST., 18-26 WARD)

2-FULL NAME Mary Louise Ford

(a) RESIDENCE No. 314 N. Carrollton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas

6 DATE OF BIRTH (month, day, and year) ? 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Agnes G. James (Address) 314 N Carrollton ave

15 Filed DEC 16 1929 C. HAMILTON JONES, Registrar By DKG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1929, to Dec 14th 1929, that I last saw her alive on Dec. 14th, 1929, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocardial Insufficiency

(duration) 2 yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Geo. H. Lauenberger M. D.

12-14 1929 (Address) 2215 N. Monroe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 12/16/1929

20 UNDERTAKER Wm. Ls. H. Holland — ADDRESS 163 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 E 51992

1—PLACE OF DEATH Baltimore City Hospitals (C. H.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriet Baker

(a) RESIDENCE NO. 680 Josephine st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lottie Kirkland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed DEC 16 1929 19 C. HENDERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5 29, 19 to Dec. 14 19 29

that I last saw her alive on Dec. 14, 19 29

and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous pleurisy with effusion

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) M. D.

12-14 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 12/16/1929

20 UNDERTAKER Geo. Geo. H. Holland 1160 N. Druid Hill — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-06 E 51993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nellie Graves

(a) RESIDENCE No. 1705 Montpelier ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Graves

6 DATE OF BIRTH (month, day, and year) Jan. 7th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ...min.
✓	68	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John H. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. L. Jacobs

(Address) 1705 Montpelier Ave. H

15 Received DEC 16 1929, 19 C. HAMILTON BELT, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 13, 1929, that I last saw h er alive on Dec 13, 1929, and that death occurred, on the date stated above, at 1:30 a m

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Mastagna, M. D.

, 19 (Address) W. Balto & Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL 12-16 1929

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1386 Lafayette Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51994

CERTIFICATE OF DEATH

1929

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St., 26-42 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugenie Mueller

(a) RESIDENCE NO. Cor Hamilton & Valiquet aves (Nitter) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? / yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) May 12/1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
✓	22	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Governess
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Mueller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Ruettiger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Carl Sachs (Bro-in-law)
(Address) 5301 E. Hamilton Ave

15 Filed ..., 19.. C. HUMSON JONES, Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

4pistol Shot Wounds-one injured Spinal Cord at 7th cervical.

Homicide

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? nr 5301 E. Ham. Ave Hamilton

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/14/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Dec 16 1929
20 UNDERTAKER	ADDRESS
M. W. E. Dippel	21 E. Oliver St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51995

HEALTH DEPARTMENT—CITY OF BALTIMORE

124

E 51995

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital.

REGISTERED NO. 12-44

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jacqueline Meyers

(a) RESIDENCE NO. 3511 N. Calvert ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-28-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John Ambrose Meyer

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Nagle

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant John A. Meyer.
(Address) 3511 N Calvert St

15 Filed ..... 19..... C. ELLISON JONES,
Registrar

DEC 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15-29

17

I HEREBY CERTIFY, That I attended deceased from 11-25, 1929, to 12-15, 1929,

that I last saw h[illegible] alive on 12-15, 1929

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Pyemia

..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Liver Abscess

..... (duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of various.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Gyhs, M. D.

12/15, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	12-16 1929
20 UNDERTAKER E & B Hasle	ADDRESS 115 E [illegible] St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 51996 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51996

135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John Pfeifer

(a) RESIDENCE NO. 2800 (Usual place of abode) Kentucky Ave ST., WARD

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Josephine Pfeifer

6 DATE OF BIRTH (month, day, and year) Nov. 22 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. Pfeifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Woodrow

(Address) 2800 Kentucky Ave

15 Filed DEC 16 1929, 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14- 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-24, 1929, to 12-14, 1929,

that I last saw him alive on 12-14, 1929

and that death occurred, on the date stated above, at 12:55 A m.

The CAUSE OF DEATH* was as follows:

Cardiac failure -

(Post-Operative)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Prostatectomy -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-8-29

Was there an autopsy? Yes No.

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Immanuel Cemetery — DATE OF BURIAL: 12-17 1929

20 UNDERTAKER: Mrs Chas A Rohde — ADDRESS: 2327 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Bks.

E 51997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 51997

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1913 E North ave ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margarette Grimm

(a) RESIDENCE NO. 1913 E North ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2nd 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George E Grimm

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Marya Fuhs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Joseph C Grimm
(Address) 1913 E North ave

15 Filed ..... 19 ..... C. HAMPSON JONES
Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from November 25, 1929, to December 13, 1929, that I last saw h/er alive on December 13, 1929, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard Woolsey, M. D.

12/15/, 1929 (Address) 530 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 17th 1929
20 UNDERTAKER M. D. George Schilling & Sons	ADDRESS 1126 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 51998

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 542 N. Central ave ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George C. Pfeltz

(a) RESIDENCE NO. 542 N. Central ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 11 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary E Pfeltz

6 DATE OF BIRTH (month, day, and year) Jan 8th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
✓	81	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cost. Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George Pfeltz

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Mooney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mary E Pfeltz

(Address) 542 N Central ave

15 Filed DEC 16 1929, 19 C. HERBERT JONES, Jr.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Dec 14, 1929

that I last saw him alive on Dec 14, 1929

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

12/14, 1929 (Address) 733 Arequith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 17th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1116 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 51999

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2344 Eutaw Place ST. 13-54 WARD)

2—FULL NAME Gertrude B. Kraus

(a) RESIDENCE NO. 2344 Eutaw Place ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 9 mos. 13 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo H. Kraus

6 DATE OF BIRTH (month, day, and year) Mar 1st 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry M. Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Helen J. Floss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Geo H. Kraus

(Address) 2344 Eutaw Pl

15 Filed ..... 19 .....

(CHAMPIONS) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/29

17 I HEREBY CERTIFY, That I attended deceased from 11/2/29, 19..., to 12/14/29, 19..., that I last saw h.e alive on 12/13/29, 19..., and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Cardiac Exhaustion

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (duration) 25 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? [redacted] Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur Tebb M.D., M. D.

, 19 (Address) 318 Hearst Tower

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cem.	12/16/1929
20 UNDERTAKER	ADDRESS
Harid. Sondheim	118-20 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 16 1929

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52000

CERTIFICATE OF DEATH.

35 E 52000

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE. (No. Catons & Welkens Aves ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Fogle

(a) RESIDENCE NO. ~~2502 Dudley~~ 1135 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) N Y.

PARENTS

10 NAME OF FATHER Howard Fogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Y

14 Informant Howard Fogle

(Address) 1135 W. Lombard

15 Filed DEC 16 1929 C. H. WILLIAMS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-4, 1929, to 12-15, 1929.

that I last saw him alive on 12-15, 1929,

and that death occurred, on the date stated above, at 6 20 p. m.

The CAUSE OF DEATH* was as follows:

Leucaemia - Stomach area

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood examination

(Signed) Irving Breuer M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 17, 1929

20 UNDERTAKER: F. Vernon Keebler — ADDRESS: 532 Hollins St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

E 52001

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 52001

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 25-11 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodore Durham

(a) RESIDENCE NO. 4200 Curtis Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3. 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Taxi driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Waverton Bros

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER James E Durham

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Lawrence

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Wm Keating
(Address) 1327 Catalina Ave

15 Filed DEC 16 1929, 19 C. J. [illegible], Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16-29

17 I HEREBY CERTIFY, That I attended deceased from 11-16, 1929, to 12-16, 1929, that I last saw him alive on 12-16, 1929 and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bilateral empyema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/21 12/5 12/11

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

12/16, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	12/18 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

E 52002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52002

CERTIFICATE OF DEATH

128

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3439 Guilford Terrace ST., 49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hugh L. Nagruder

(a) RESIDENCE NO. 3439 Guilford Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna L. Nagruder

6 DATE OF BIRTH (month, day, and year): June 27 1860

7 AGE: 69 Years 59 | Months 10 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Architect

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

086

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Hamlin Nagruder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Harriett Hixson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Anna L. Nagruder

(Address) 3439 Guilford Terrace

15 Filed DEC 16 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 16, 1929, that I last saw him alive on Dec 15th 1929 and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Dyspepsia & Bowels

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Microscopical

(Signed) H. L. Kerr M. D.

, 19 (Address) Kenilworth apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Dec 18th 1929

20 UNDERTAKER: Putnam & Love

ADDRESS: 1223 W. Lafayette Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52003

CERTIFICATE OF DEATH

181-003

E 52003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 8-17 Ward)

2-FULL NAME Clarence A. Kirby

(a) RESIDENCE NO. 1921 E. Federal St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah J. Kirby

6 DATE OF BIRTH (month, day, and year) Sept 24/1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	69	2	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City Fire
(c) Name of employer Dept.

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER XxxxxxxKirby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ellen Richardson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs. Wm. Starr
(Address) 0101 Carter Ave

15 Filed 12/10 19 29 H. LAWSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fuel Gas Poisoning from Furnace
Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Lawson Jones, M. D.

12/10, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 17 1929
20 UNDERTAKER	ADDRESS
Young Hirsch & Sons Inc	130 E Eagle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

DEC 10 1929

Cor.—10-10-29—A Co.—100 Bks.

E 52004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

181 E 52004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1921 E. Federal St., 8-17 Ward)

2-FULL NAME Sarah J. Kirby

(a) RESIDENCE NO. 1921 E. Federal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence A. Kirby

6 DATE OF BIRTH (month, day, and year): Sept 22/1800

7 AGE ✓	Years	Months	Days	IF LESS than 1 day hrs. or min.
	03	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): At home 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: John A. Foote

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Mrs. Wm. Starr (Daughter)
(Address): 9101 Carted Ave

15 Filed DEC 18 1929 H. V. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fuel Gas Poisoning from furnace
(Accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Foote, M. D.

12/19/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 17 1929
20 UNDERTAKER	ADDRESS
Henry Hirsch Son Inc	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—8-16-29—L. F. S.—100 Bks.

E 52005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 52005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (3314 Gwynnfalls Parkway ST. 47 WARD)

2—FULL NAME Anna Fleet

(a) RESIDENCE NO. 3314 Gwynnfalls Parkway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth 26 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maurice Fleet

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Richman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Maurice ~~Hoffman~~ Fleet

(Address) 3314 Gwynnfalls Pkway

15 Filed DEC 16 1929, 19 HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16/29

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 1929, to Dec 16, 1929 that I last saw her alive on Dec 15, 1929 and that death occurred, on the date stated above, at 1:50 a. m.

The CAUSE OF DEATH* was as follows:

Glioma of Right Cerebral Hemisphere. Metastasis

(duration) yrs. 10 mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? at home in Baltimore

Did an operation precede death? Yes Date of 3/31/29

Was there an autopsy? None

What test confirmed diagnosis? Section of tumor tissue

(Signed) Edwin Zapffe, Jr., M. D.

. 19 (Address) Lafayette Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrer Rosedale	12/16 19 29
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balt

INFORMATION, WITH CAUSE OF DEATH—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52006

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52006

88

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 N. Wolfe ST. 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn E. Rummel

(a) RESIDENCE NO. 2005 N. Wolfe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year): Apr. 24/1907

7 AGE: Years 22 | Months 7 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): Health Dept

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Albert Rummel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Fredericka Kahler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Fredericka Rummel

(Address): 2005 N. Wolfe St.

Filed DEC 16 1929

C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 14/29

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to December 14, 1929, that I last saw h[illegible] alive on December 14, 1929, and that death occurred, on the date stated above, at 3 25 a.m.

The CAUSE OF DEATH* was as follows:

Septicaemia due to Streptococcus Viridans

Acute Endocarditis

(duration) yrs. 6 mos. 17 ds.

CONTRIBUTORY (Secondary): Acute nephritis and secondary anaemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical clinical picture, blood culture + streptococcus viridans

(Signed) Albert Rummel M. D.

12/16, 1929 (Address) 2005 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem.

DATE OF BURIAL: Dec 17 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St.

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52007 — E 52007

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2615 Lehman ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M E Rehmann

(a) RESIDENCE NO. 2615 Lehmann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Rehmann

6 DATE OF BIRTH (month, day, and year): Jan. 19, 1871

7 AGE: Years 58 | Months 10 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fredk. Bohne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Herman H. Mahlstedt

(Address) 5509 Pilgrim Rd.

15 Filed C. HAMPSON JONES M. D. Registrar

C 1 6 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1928, to Dec 15, 1929, that I last saw h alive on Dec 14, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ovarium

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. 7 mos. 6 ds.

Cachexia (duration) 1 yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) J. H. Rehmann M. D.

12/16/29 (Address) 1729 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Dec. 18, 1929

20 UNDERTAKER: Chas. W. Dill.

ADDRESS 3109 Fredk. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52008

CERTIFICATE OF DEATH

E 52008

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 31

CITY OF BALTIMORE: (No. ..... ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Wilson

(a) RESIDENCE NO. 805 Fremont ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Betty Ham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed DEC 16 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1929, to Dec. 15, 1929, that I last saw her alive on Dec. 15, 1929, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Multiple lung abscesses

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature] M. D.

12-16-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Caoses, state (1) Means and Nature of Injory, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary cemetery — DATE OF BURIAL Dec 18 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

C 16 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52009

CERTIFICATE OF DEATH

88 ✓

E 52009

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2205 East Preston ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sylvester Rhea Watson

(a) RESIDENCE NO. 2205 East Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 10, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Union Trust Company

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene T. Watson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Ella B. Rhea

13 BIRTHPLACE OF MOTHER (city or town) Dorchester County
(State or country) Maryland

14 Informant Dr. Eugene T. Watson

(Address) 2205 E. Preston St.

15 Filed DEC 16 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Dec. 14, 1929, that I last saw h im alive on Dec. 14, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Malignant endocarditis
& cerebral embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) multiple infarction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Herman A Vorp M D, M. D.

12/14, 1929 (Address) 5106 Harford Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec. 17 1929
UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52010

CERTIFICATE OF DEATH.

101 E 52010

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Edgewood Sanitarium

CITY OF BALTIMORE: (No.) 6000 Bellona Ave (WARD) 10-11

2-FULL NAME Effie E Neas

(a) RESIDENCE NO. 14004 Mass. Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leander Neas

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE — Years: 59 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Harry E Fulds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mich.

12 MAIDEN NAME OF MOTHER: Eliz Ditch.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant (Address): Edw. B. Serrano 24 Belmont Road

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

DEC 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Dec 14, 1929, that I last saw her alive on Dec 14, 1929, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Edgewood Sanitarium

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Cl & Phy Exams

(Signed) Fred T. Hyder, M. D.

, 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 12/17 1929

20 UNDERTAKER: George A Talley — ADDRESS: Fulton & Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52011 23 — 16-007 — E 52011

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Faulkner

(a) RESIDENCE NO. 1801 Madison av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May-28-29

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Car

12 MAIDEN NAME OF MOTHER Beatrice Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 10 1929, 19 — 4967 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-9-29

17

I HEREBY CERTIFY, That I attended deceased from Nov-21, 1929, to Dec 9, 1929, that I last saw h.im alive on Dec 9, 1929 and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Malnutrition due to dysentery + gastro-enteritis (4 mos)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Prematurity (7 mos. gestation)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J J Beckford Jr, M. D.

12/11, 1929 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health	ADDRESS DEC 16 1929

JOHNS HOPKINS HOSPITAL

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

231 E 52012

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 52012

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Doggett

(a) RESIDENCE NO. 2723 Beechen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/10/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Wm H - Doggett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Cecile Ulrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 16 1929, 19 RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Thur 11-29

17

I HEREBY CERTIFY, That I attended deceased from Thur 10, 1929, to Thur 11, 1929, that I last saw him alive on Thur 11, 1929, and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1d yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes -

What test confirmed diagnosis?

(Signed) J V Bickford, M. D.

12/11, 1929 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS

DEC 16 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52013

101-001

E 52013

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 4-26 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eullie Williams

(a) RESIDENCE NO. 730 Fairmount Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Dec 12 1901~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4162 19 ... a.m. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 29, 1929, to Dec 12, 1929, that I last saw h.in alive on Dec 7, 1929 and that death occurred, on the date stated above, at 2 05 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Hackett, M. D.

12/13/29 (Address) 6 Somerset Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 16 1929

Health should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

23/E 52014

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 52014

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Irving

(a) RESIDENCE NO. 1348 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar-12-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md-

PARENTS

10 NAME OF FATHER Jack Irving

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga-

12 MAIDEN NAME OF MOTHER Alice Gilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga-

14 Informant Rondo-

(Address)

15 Filed DEC 16 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-9-29

17 I HEREBY CERTIFY, That I attended deceased from Dec-9, 1929, to Dec-9, 1929, that I last saw him alive on Dec-9, 1929 and that death occurred, on the date stated above, at 8 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Aorta

contributory Hypertension of years duration

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension years duration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James Bordley M. D.

12-14, 1929 (Address) Hunt Valley, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

E. Wilson Jones M.D. Commissioner of Health.

DEC 16 1929

DEC 16 1929

BEFORE SIGNING BE CAREFULLY INSTRUCTED. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52015

CERTIFICATE OF DEATH

74-001

E 52015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1536 N. Carey St., 15-21 Ward)

2-FULL NAME Clarence M Thomas

(a) RESIDENCE NO. 1536 N. Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 15-1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Glass Co Md
(State or country)

PARENTS

10 NAME OF FATHER Madison Thomas

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Jones

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Bertha Davis
(Address) 1536 N. Carey

Dec 16 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis (duration) ..... yrs. Sudden
CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. Hewitt M. D.
Dec 16 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	12/17 1929
20 UNDERTAKER Jame. W. Ward & Son	ADDRESS 1400 Mass

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. P. S.—100 Blks.

E 52016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 52016

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 536 N. Carey ST., 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Kunker,

(a) RESIDENCE NO. 536 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a ~~Unmarried~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Henry F. Kunker,

6 DATE OF BIRTH (month, day, and year) September 16. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Wagner,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Doberer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant: Mrs. Charles A. Hanson (Address) 534 N. Carey St.

Filed DEC 17 1929 C. ATKINSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 19 29, to Dec 14, 19 29, that I last saw h~~e~~r alive on Dec 14, 19 29 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Hypertension, Cardio vascular disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Howard M Bubert, M. D.

12/16, 19 29 (Address) 821 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL DEC 17 1929 19

20 UNDERTAKER Geo M Sutler

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52017 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 52017

32

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 16-69

CITY OF BALTIMORE: (No. 2518 Edmondson Ave. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Weir Nicholson,

(a) RESIDENCE NO. 2518 Edmondson Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) February 9.1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. A. Nicholson,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Maggie E. Weir,

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Maggie E. Nicholson
(Address) 2518 Edmondson Ave

15 Filed DEC 16 1929, 19 C. HARRISON JONES, M. D. Registrar
Rec

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Nov - 22, 1929, to December 14, 1929;

that I last saw her alive on December 14, 1929.

and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Spinal puncture

(Signed) Chester Riland, M. D.

12-16 1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL 19

20 UNDERTAKER D Geo W Little — ADDRESS

DEC 16 1929

DEC 17 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION... important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52018

CERTIFICATE OF DEATH

117 ✓ E 52018

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barnes S. Miller

(a) RESIDENCE NO. 1822 Harford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 3. 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Harry Miller,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Jennie Marie Sidley,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Harry Miller (Address) 1822 Harford Ave

15 DEC 16 1929 19 C. Harrison Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929, to Dec 14, 1929, that I last saw him alive on Dec 14, 1929 and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Acute ruptured gangrenous Appendicitis

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Paralytic ileus; generalized Peritonitis (duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 12/9/29

Was there an autopsy? no.

What test confirmed diagnosis? Clinical + operation

(Signed) Henry D. Leeds, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 19

20 UNDERTAKER Geo W Little

ADDRESS

DEC 18 1929

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52019 (2E 1747 Wht) (E 52019)

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion Christian

(a) RESIDENCE NO. Box 495 - Hampton ST., Va WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 8 6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va -

PARENTS

10 NAME OF FATHER Samuel Christian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Rachael Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Friends -
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 16 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec - 16, 1929, that I last saw him alive on Dec - 16, 1929 and that death occurred, on the date stated above, at 9 55 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/13/29

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H. C. Smith, M. D.

12/16, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laeger Va	12/16/29
20 UNDERTAKER	ADDRESS
Joseph Owens	221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

DEC 16 1929

Cor.—10-10-29—A Co.—100 Bks.

Soellers

E 52020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52020

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1104 E. Eager St., Ward) 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Soellers

(a) RESIDENCE NO. 1104 E. Eager St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward Soellers

6 DATE OF BIRTH (month, day, and year) Aug 1/1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Robel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Robel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Edward Soellers
(Address) 1104 E. Eager St

15 Filed 1929 G. H. IMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Probable Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/16, 1929 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 12/17/1929

20 UNDERTAKER George J. Ruth — ADDRESS 1725 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52021

E 52021

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 818 Warner St. St., Ward)

2-FULL NAME Mary Harris.(O)

(a) RESIDENCE NO. 818 Warner St. St., 21-31 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of George Harris.(O)

6 DATE OF BIRTH (month, day, and year) November 1887.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	42	1	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Lemuel Jackson.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mollie Jackson.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant George Harris.(C) husband.
(Address) 818 Warner St.

15 Filed (19) C. HAMPSON JONES, M. D.
Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Steinhardt, M. D.

12/16/29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brookes Chapel — DATE OF BURIAL 12-17-1929

20 UNDERTAKER Calvert Co Md John H. Toadvine Lewd Mill — ADDRESS 1027

C 16 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 52022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., Ward)

2-FULL NAME Mrs. Mary C. Reuter

(a) RESIDENCE NO. 1033 N. Fulton Ave Ward 16-22

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 2 ds. 4 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Reuter

6 DATE OF BIRTH (month, day, and year) May 18-1848

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	81	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER John Zeller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna B. Endsor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wm. Blank
(Address) 1033 N. Fulton Ave

15 Filed DEC 16 1929 C. HUMPSON JONES, Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured right femur

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1033 N. Fulton Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

12-16. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	12-17-1929
20 UNDERTAKER	ADDRESS
Wm. Cook	1217 St. Paul St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52023

CERTIFICATE OF DEATH

74-001 E 52023

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 2334

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alonzo F. Brewer

(a) RESIDENCE NO. 1705 Marshall St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed DEC 16 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-15-29

17 I HEREBY CERTIFY, That I attended deceased from 2-21-24, 19, to 12-15-29, 19,

that I last saw h im alive on 12-15-29, 19

and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, Rt.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist: P.C: Lab: Autopsy

(Signed) Marion M. McLean, M. D.

12-16, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Dec 18 1929

20 UNDERTAKER: D. W. Cook — ADDRESS: 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52024

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52024

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Baltimore Md. ST., WARD) 25-77

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isador Leslchynsky

(a) RESIDENCE No. 1628 Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalena Seslchynsky

6 DATE OF BIRTH (month, day, and year) Dec 17-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs. Mikolaj 1605 Eutaw ave

15 Filed DEC 16 1929 C. HAMPSON JONES, M. D. Registrar

Mat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16 19-29

17 I HEREBY CERTIFY, That I attended deceased from 12-11 .19 29 to 12-16 .19 29

that I last saw him alive on 12-16 .19 29,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, Sortitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Burns, M. D.

.19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Brooklyn — DATE OF BURIAL Dec 18 1929

20 UNDERTAKER John F Weber & Co — ADDRESS Chester

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52025

232170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 52025

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Gunzelman 2-4

(a) RESIDENCE NO. 1836 Eastern Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Gunzelman

6 DATE OF BIRTH (month, day, and year) 4/2/80

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	49	7 8	23 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House - wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer — 037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harry Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address)

15 Filed DEC 16 1929 C. H. EMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15-29

17 I HEREBY CERTIFY, That I attended deceased from 12-12-, 1929, to 12-15-, 1929, that I last saw h[er] alive on 12-15, 1929 and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Head of Pancreas

? Cerebral Hemmorhage

Bronchopneumonia

(duration) ? yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles M McClure, M. D.

12/15, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Dec 18 1929

20 UNDERTAKER Jno C. Miller & Son — ADDRESS 2334 Jeff

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

C 16 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52026

CERTIFICATE OF DEATH.

46 E 52026

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3238 Belair Rd. ST., WARD) E-45

2-FULL NAME Emma E Seabrease

(a) RESIDENCE NO. 3238 Belair Rd. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Seabrease

6 DATE OF BIRTH (month, day, and year): Nov. 29 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54		17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Charles Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Emma E. Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Harry Seabrease

(Address): 3238 Belair Rd

15 Filed DEC 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-16 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Dec 16, 1929, that I last saw her alive on Dec 16, 1929, and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Myocardial

Insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Uteri

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) David Miller, M. D.

12-17, 1929 (Address) 1503 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pachwood Cemetery — DATE OF BURIAL: Dec. 19 1929

20 UNDERTAKER: E. Miller & Son — ADDRESS: 2334 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

C 16 1929

Spec.—8-16-29—L. F. S.—100 Bks.

E 52027

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52027

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Orleans ST., WARD) 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernie R. Nugent

(a) RESIDENCE NO. 2407 Orleans ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry R Nugent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jennie M. Bayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry R Nugent

(Address) 2407 Orleans St

15 Filed 19 C. HAMPSON JONES, Registrar

DEC 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 19 29, to Dec 14, 19 29

that I last saw him alive on Dec 14, 19 29

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Empyema

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Pulmonary Edema yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Aspiration of Chest by needle

Was there an autopsy? No Dec 14-29

What test confirmed diagnosis?

(Signed) Wm E Geyer, M. D.

19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 17 1929
20 UNDERTAKER	ADDRESS
Thos O'Mitchell & Son	Eutaw

REGISTRATION cannot be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52028

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52028

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH B

REGISTERED NO.

CITY OF BALTIMORE: (No. 6011 Sycamore Road ST., WARD) 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Harris Cooper, Jr.

(a) RESIDENCE No. 6011 Sycamore Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 13, 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, 10 hrs. or 15 min.
	2		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Harris Cooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) San Francisco, Cal.

12 MAIDEN NAME OF MOTHER Charlotte Lambert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mr Robert Cooper
(Address) 6011 Sycamore Road

15 Filed 12-16 1929
C. H. MASON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1929, to Dec. 16, 1929, that I last saw him alive on Dec. 16, 1929, and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Tabole, M. D.

12-16 1929 (Address) 6014 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 17 1929

UNDERTAKER John O Mitchell & Son

ADDRESS 1917 Eutaw

C 16 1929

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52029

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52029

CERTIFICATE OF DEATH

14-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1000 Caton Ave ST., WARD)

2-FULL NAME Bertha Thompson 2677

(a) RESIDENCE No. 2321 Graysmere Oak Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: John Bernard Thompson deceased.

6 DATE OF BIRTH (month, day, and year)

7 AGE: 58 (Years | Months | Days | If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Jeremiah Cowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jenkins Memorial Hospital

(Address) 1000 Caton Ave

15 Filed DEC 17 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 11. 1929, to Dec. 14 1929, that I last saw h[illegible] alive on Dec. 14 1929, and that death occurred, on the date stated above, at 10-05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brunner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 12-17-1929

20 UNDERTAKER: M. Tabor & Son

ADDRESS: 1827 W North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52030

CERTIFICATE OF DEATH

90

E 52030

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Anna Warner 10-14

(a) RESIDENCE NO. 1121 Aisquith ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER John Wayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Balto. City Hospitals

15 Filed DEC 17 1929 4168 W. Stark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-11-29

17 I HEREBY CERTIFY, That I attended deceased from 8-25-29, 19..., to 12-11-29, 19..., that I last saw her alive on 12-11-29, 19..., and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Senile Dementia

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.C.

(Signed) Warren H. McLean, M. D.

12-13, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 16 1929
20 UNDERTAKER Commissioner Health	ADDRESS

DEC 17 1929

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52031

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~STILL BIRTH NO.~~

E 52031

CERTIFICATE OF DEATH

161-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 644 Portland St. 12-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Gracyk

(a) RESIDENCE NO. 644 Portland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-15-29

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

7 Months 1 Hour

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Michael Gracyk

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Krawonsky

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Mary Gracyk 644 Portland St

(Address)

15 [illegible]

19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-29

17 I HEREBY CERTIFY, That I attended deceased from 1-15-29, 19..., to 1-18-29, 19...

that I last saw h... alive on 1-17-29, 19...

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Prematura Birth

(duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs...mos...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Dan M. D.

(Address) 527 Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 16 1929
20 UNDERTAKER	ADDRESS
Wm. A. Leithauser	423 S Paca St

Do not write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52032

CERTIFICATE OF DEATH

31 E 52032

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Overton

(a) RESIDENCE NO. 1525 E. Monument St. WARD 7-9
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed DEC 18 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-29

17 I HEREBY CERTIFY, That I attended deceased from 12-10, 1929, to 12-14, 1929

that I last saw h[illegible] alive on 12-14, 1929

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Jas Hammond M. D.

19 (Address) City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion	Dec. 17 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland Ave

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52033

CERTIFICATE OF DEATH

188-103

E 52033
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. John Hopkins Hosp St., Ward)

2-FULL NAME Florence Williams 7-13

(a) RESIDENCE NO. 809 Rutland St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Williams

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stock
(b) General nature of industry, business, or establishment in which employed (or employer) Dom
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Wash DC

PARENTS

10 NAME OF FATHER Lewis Brune

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant
(Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
Registrar

DEC 18 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Cervical Vert Struck & knocked down by auto ac

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Traumatic Shock & See. Paralysis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? in front of 804 Gay St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. A. Frame M. D.

12/16 1929 (Address) 2939 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cemetery	Dec 17 1929
20 UNDERTAKER	ADDRESS
Wm A. Snowden	1708 Madison Ave

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52034

CERTIFICATE OF DEATH

74-001

E 52034

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1024 N Vincent St., Ward) 16-22

2-FULL NAME Charles Moore

(a) RESIDENCE NO. 1024 N. Vincent St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1-1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mamie Moore
(Address) 1024 N. Vincent

15 Filed ..... 19.. C. HAMILTON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy find that said deceased came to death (by violence, suicide, accident, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) ..... yrs. Sudden
CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Negative
(Signed) H. Radbruch, M. D.
Dec 14 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-17 1929
20 UNDERTAKER	ADDRESS
Lowe & Eareckson	Balto

DEC 7 1929

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every item of Informa-

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52035

CERTIFICATE OF DEATH

31 E 52035

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1124 Whatcoat St., Ward) 16-22

2-FULL NAME James White

(a) RESIDENCE NO. 1124 Whatcoat St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 040

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER James R White

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Carrie White
(Address) 1124 Whatcoat St

15 Filed DEC 1 1929 H. Hilton Jones M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

Dec 16 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Md

DATE OF BURIAL 12-17 1929

20 UNDERTAKER Daniel Easton

ADDRESS 916 Park

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EC 1 71929

Spec.—2-29-28—L. F. S.—500 Blks.

E 52036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52036

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Margaret Scott

(a) RESIDENCE NO. 8 N. Bethel ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Janus Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed DEC 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15-29

17 I HEREBY CERTIFY, That I attended deceased from 1-6-29, 19..., to 12-15-29, 19..., that I last saw her alive on 12-15-29, 19..., and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

..... (duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Marvin W. McLean, M. D.

12-16, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cemetery	Dec. 18th 1929
20 UNDERTAKER	ADDRESS
Theodore S. White	1131 W. Fayette St

Important. See instructions on back of certificates.

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Cor—10-10-29—A Co.—100 Bks.

E 52037 Smith E. 52037

E 52037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 E 52037

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute to Sinai Hospotal

City of Baltimore: (No. ..... St., ... Ward) 2-4

2-FULL NAME Linwood Smith

(a) RESIDENCE NO. 2020 E. Pratt St., ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11/1929

7 AGE	Years	Months	Days 4	IF LESS than 1 day ..... hrs. or ..... min.
		9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Smith

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ida [illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant .....
(Address) Jewish Children Society Guardian

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

DEC 17 1929 per [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (left)

Oedem of Larynx

..... (duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (Secondary) Whooping Cough

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? Yes at Sinai

What test confirmed diagnosis? .....

(Signed) J. H. Hace M. D.

12/16/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cemetery — DATE OF BURIAL 12/17/1929

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto st

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52038

CERTIFICATE OF DEATH

90

E 52038

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Mill Race Road ST. WARD) 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Martin

(a) RESIDENCE NO. 3422 Chestnut Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late John M. Martin

6 DATE OF BIRTH (month, day, and year): Jan 5 1841

7 AGE: Years 88 Months 11 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Dora J. Martin

(Address) 1518 Mill Race Road

15 FILED DEC 1 1929, 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-17, 19 29, to 12-16, 19 29, that I last saw h[illegible] alive on 12-16, 19 29, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C J Edmunds M. D.

12-17 19 29 (Address) 3201 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden

DATE OF BURIAL: Dec 19 1929

20 UNDERTAKER: Chunowith Lon

ADDRESS: 3615 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52039

CERTIFICATE OF DEATH

90 E 52039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Elm Court W 33rd St., Ward)

2-FULL NAME Wilkes B. Carr 13-51

(a) RESIDENCE NO. 925 W 33rd St., 13 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Baltimore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hucksters Producer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Benjamin Carr

11 BIRTHPLACE OF FATHER (city or town) Unk.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Willis

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Steven M. Carr
(Address) 3112 Virginia Ave.

Rec'd ... 1929 HARRISON JONES, ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Goiter
Angina Pectoris
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Mosser, M. D.

12/16, 1929 (Address) 962 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL Dec 18 1929

20 UNDERTAKER Chenowethlon

ADDRESS 2405 Eutaw Ave

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52040

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52040

CERTIFICATE OF DEATH 167-001

1-PLACE OF DEATH

City of Baltimore: (No. 3416 Kenwick Road St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Bowen

(a) RESIDENCE NO. 3505 Kenwick Road Ward 13-52

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Mary Bowen

6 DATE OF BIRTH (month, day, and year) Nov 2 1870

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
59	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labour.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Elijah Bowen

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Jane

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Augusta Bowen
(Address) 3505 Kenwick Rd

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bass. Poison

(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Morrissey M. D.

12-14 19 29 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL Dec 19 1929

UNDERTAKER Shanahan Bros

ADDRESS 3415 Chestnut

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 17 1929

Spec.—8-16-29—L. F. S.—100 Bks.

E 52041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

42 E 52041

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 N. Chester ST., WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Brown

(a) RESIDENCE NO. 1414 N. Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of George A. Brown

6 DATE OF BIRTH (month, day, and year) 2nd Knw

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Georg Speiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Henry G. Brown

(Address) 3119 Dudley St

15 DEC 17 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30th, 1929, to Dec. 16—, 1929, that I last saw h Ex alive on Dec. 16—, 1929 and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Tularemia

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

12/16/1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec. 19 1929

20 UNDERTAKER Henry Hoech & Sons Inc — ADDRESS 1301 E Eager St

C 1 71929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 31 E 52042

1—PLACE OF DEATH United States Marine Hospital, Baltimore, Maryland.

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 2-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carl J. Michelsen

(a) RESIDENCE NO. 1704 Thames Street, Baltimore, Maryland ST. WARD Norway.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. 10 How long in U. S., if foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman 086

(c) Name of employer SS Bellepline

9 BIRTHPLACE (city or town) Norway
(State or country)

10 NAME OF FATHER Carl J. Michelsen

11 BIRTHPLACE OF FATHER (city or town) Norway
(State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Norway
(State or country)

PARENTS

14 Informant U.S. Marine Hospital Records
(Address) Baltimore, Maryland.

15 Filed DEC 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1929, to Dec. 15, 1929, that I last saw him alive on December 15, 1929 and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis, of larynx

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and laboratory

(Signed) Ralph E. Porter M. D.
Ralph E. Porter

12-15-29 (Address) U.S. Marine Hospital, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden

DATE OF BURIAL Dec. 17, 1929

20 UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North Ave

DO NOT WRITE IN THIS SPACE

C 1 7 1929

IF DEATH in plain type, that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52043

CERTIFICATE OF DEATH

90 E 52043

1—PLACE OF DEATH

REGISTERED NO. 1250

CITY OF BALTIMORE: (No. 410 E. 22nd. St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William C. McAllester

(a) RESIDENCE NO. 410 E. 22nd. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of M. Louise McAllester

6 DATE OF BIRTH (month, day, and year) Mch. 9, 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Superintendent

(c) Name of employer Pullman Co.

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER George McAllester

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Brunswick

12 MAIDEN NAME OF MOTHER Hannah Phinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant G. Bowne McAllester

(Address) 410 E. 22nd St.

15 Filed Dec 1 1929 C. HUMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 16, 1929

that I last saw h[illegible] alive on Dec 16, 1929

and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Black M. D.

, 19 (Address) 532 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec. 18 1929

20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52044

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Druid Hill Ave ST., WARD) 14-70

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophronia Hill

(a) RESIDENCE NO. 1420 Druid Hill Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cornelius Hill

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Orange Co. Va

PARENTS

10 NAME OF FATHER: Peter Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Bettie Roy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Ella Cook

(Address) 1423 Dandelle ave

15 Filed DEC 7 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to Dec. 14, 1929 that I last saw her alive on Dec. 14, 1929 and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage and Nephritis (Interstitial)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Uremic Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H H White, M. D.

19 (Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Dec 17 1929

20 UNDERTAKER: T B Nelson — ADDRESS 1303 Pennsylvania

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52045

CERTIFICATE OF DEATH.

129

E 52045

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Presstman ST., WARD) 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Burris

(a) RESIDENCE NO. 1621 Presstman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Burris

6 DATE OF BIRTH (month, day, and year): March 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co. Va

PARENTS

10 NAME OF FATHER: Wm Beverly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: — — —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Lillie Adams. 1621 Prestman St

15 Filed OCT 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/15 - 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/5 - 1929, to 12/15 - 1929,

that I last saw h[illegible] alive on 12/15 - 1929,

and that death occurred, on the date stated above, at 9 05 A m.

The CAUSE OF DEATH* was as follows:

Ac. Cholecystitis

Chr. Nephritis & Uremia

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Ruth, M. D.

12/16, 1929 (Address) 2134 N [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: Dec 18 1929

20 UNDERTAKER: T E Nelson

ADDRESS 1307 Presstman St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52046

CERTIFICATE OF DEATH

128 E 52046

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N. Appleton ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora Perry

(a) RESIDENCE NO. 233 N. Appleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ernst Perry

6 DATE OF BIRTH (month, day, and year) Dec 31 1854

7 AGE Years 37 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Geo. Barnes

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md (State or country)

12 MAIDEN NAME OF MOTHER Mary T. Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Estelle Wax (Sister) (Address) 233 N Appleton St

15 Filed ..., 19... [illegible] JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 11 1929, to Dec 16 1929, that I last saw her alive on Dec 14 1929, and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Gross examination

(Signed) W. J. [illegible] M. D.

, 19 (Address) 1618 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion

DATE OF BURIAL Dec 17, 1929

20 UNDERTAKER Joseph A Lively

ADDRESS 709 N Mount St

IMPORTANT: Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52047

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52047

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 21-27

CITY OF BALTIMORE: (No. 1817 W. Lexington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Breidenstein

(a) RESIDENCE NO. 1817 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 17th.1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	4	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harold Breidenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Edna Bussard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mr. Harold Breidenstein

(Address) 1817 W. Lexington St.

15 Filed DEC 17 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.16th.1929

17 I HEREBY CERTIFY, That I attended deceased from December 7, 19 29, to December 16, 19 29, that I last saw her alive on December 16, 19 29 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. Nevelstein M. D.

. 19 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 17th, 29

20 UNDERTAKER — ADDRESS

John J. Cowan & Son 901 Hollins St.

DEC 17 1929

Please write plainly, as much of it may be printed. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-29—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52048

CERTIFICATE OF DEATH. 74-001 E 52048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST., WARD)

2-FULL NAME Mrs Elizabeth Zell

(a) RESIDENCE NO. 126 S. Kossuth ST., 20-70 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E Zell

6 DATE OF BIRTH (month, day, and year): Dec. 11, 1859.

7 AGE — Years: 70 — Months: — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Fugmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmine Pottgieser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): James Seybold. 126 S Kossuth St.

15 Filed ..... 19.... HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-14 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-2, 1929 to 12-14, 1929

that I last saw h[illegible] alive on 12-14, 1929

and that death occurred, on the date stated above, at 8.35 P m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Breese M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec 18 1929

20 UNDERTAKER: Patrick A. Nannon — ADDRESS: 152 Paloma St

DEC 17 1929

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Bks.

important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52049

129 E 52049

REGISTERED NO.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 N. Monument ST., WARD) 6-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Horace Griffin

(a) RESIDENCE NO. 10 N Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

3a If married, widowed, or divorced, HUSBAND of (or WIFE of) Estella Griffin

6 DATE OF BIRTH (month, day, and year) about 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, odd jobs

(b) General nature of industry, business, or establishment in which employed (or employer) Long duration

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Va

PARENTS

10 NAME OF FATHER James Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Estella Griffin (wife)

(Address) 10 N Monument

15 Filed ..... 19..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 (?), 19 29, to Dec 14, 19 29, that I last saw h[illegible] alive on Dec 13, 19 29, and that death occurred, on the date stated above, at 3 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia also Markes Hypertension

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Hartley M. D.

12/15, 19 29 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashley County	Dec 17 29
20 UNDERTAKER A. Walston Davis	ADDRESS 413 E Lexington

Spec.—6-9-19—H. P. Co.—1000 Bks.

52050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 52050

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Birchwood Ave. ST.; WARD) 27-44

2-FULL NAME Carl F. Mueller Jr.

(a) RESIDENCE. No. 5106 Birchwood Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 23rd 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Carl F. Mueller

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Mildred Cross

13 BIRTHPLACE OF MOTHER (city or town) City. (State or country)

14 Informant Carl F. Mueller

(Address) 5106 Birchwood ave.

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar

per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 . 19 29 . to Dec 15 . 19 29 .

that I last saw him alive on Dec 15 . 19 29 .

and that death occurred, on the date stated above, at 2:45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinic of Nephritis

(Signed) Walter C. Bacon, M. D.

12/16/29 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	12/17/ 1929

20 UNDERTAKER E. J. Fanning & Son - 1386 Lafayette ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 1 71929

Cor.—10-10-29—A Co.—100 Bks.

E 52051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 52051

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. St., Ward)

2-FULL NAME George W. Duckett.

24-33

(a) RESIDENCE NO. 1039 William St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 2 mos. 11 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, HUSBAND of Annie Duckett.

6 DATE OF BIRTH (month, day, and year) October 3, 1899.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George W. Duckett.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Catherine Crosby.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Informant Mary Miller. (sister)
(Address) 140 N. Clement St.

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from a step.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1039 William St. Dec. 14, 1929
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto A. Reinhardt M. D.

12/16 19 29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross G. A. C. DATE OF BURIAL Dec. 17 19 29

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light St.

DEC 17 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52052

CERTIFICATE OF DEATH

74-001 E 52052

REGISTERED NO. 16-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Arunah Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Charles Garrott

(a) RESIDENCE NO. 2405 Arunah Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 years yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick County Md.

PARENTS

10 NAME OF FATHER John Garrott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Hackney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Warren

(Address) 2405 Arunah Ave.

15 Filed DEC 17 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Dec 15, 1929, that I last saw h[illegible] alive on Dec 13, 1929 and that death occurred, on the date stated above, at 4 C m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lumpkin, M. D.

12/17 1929 (Address) 3409 Callaway Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mark's Cemetery, Frederick County, Md.

DATE OF BURIAL Dec. 18, 1929

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mahlon B. Mitchell

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52053

CERTIFICATE OF DEATH

129 E 52053

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (N Annadale Cem. 2 WARD)

2—FULL NAME Mary Berliner 13-59

(a) RESIDENCE NO. Annadale Cem. 2 WARD
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE Emanuel Berliner

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va.

PARENTS

10 NAME OF FATHER Samuel Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mr. Sam'l Berliner
(Address) Annadale Cem.

15 Filed DEC 17 1929 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Dec 16, 1929, that I last saw h.. alive on Dec 16, 1929 and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Dent, M. D.

12-17 1929 (Address) Temple Gardens Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 12/18/1929

20 UNDERTAKER David Sondheim

ADDRESS 116 20 W. Mt. Royal Ave.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52054

CERTIFICATE OF DEATH

74-001 E 52054

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Regester ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Rotte 2-4

(a) RESIDENCE NO. 319 S. Regester ST., 2 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Rotte

6 DATE OF BIRTH (month, day, and year) May 13th 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Rotte

(Address) 319 S. Regester St.

15 Filed DEC 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 19 29, to Dec 15th, 19 29

that I last saw her alive on , 19 29

and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L Wimer, M. D.

12/16, 1929 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Dec 18th 1929

20 UNDERTAKER Lilly & Linker Inc

ADDRESS 400 E. Monument St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52055

CERTIFICATE OF DEATH

90 E 52055

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 26 WARD) 24

2—FULL NAME Edward Henninger

(a) RESIDENCE NO. 1929 Fleet ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth ? yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie

6 DATE OF BIRTH (month, day, and year) Dec. 1876 ~~Unknown~~

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Unknown~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Henninger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kime

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed DEC 17 1929, 19.. HARRY JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-29

17 I HEREBY CERTIFY, That I attended deceased from 12-6-29, 19.., to 12-14-29, 19.., that I last saw h.. in life on 12-14-29, 19.. and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, ~~over~~ Chronic Endo

(duration) .. yrs. over 19 mos. .. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) .. yrs. .. mos. .. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? ~~No~~ Yes

What test confirmed diagnosis? Hist. P.C. Lab

(Signed) Marvin M. McLean, M. D.

12-14, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Dec 18 1929
20 UNDERTAKER	ADDRESS
Kelly + Zeiler Inc	403 E. Monument

N. B.—WRITE PLAINLY. Information should be given on back of certificate. See instructions on back of certificates. All questions are important.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 52056

REGISTERED NO. 15-58

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carolyn Kelley

(a) RESIDENCE NO. 4000 Park Ht. Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Kelley 2

6 DATE OF BIRTH (month, day, and year)

7 AGE: about Years: 32 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Scheller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital records

(Address)

15 Filed 7-1928, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929 to Dec 14, 1929

that I last saw her alive on Dec 14, 1929

and that death occurred, on the date stated above, at 1 42 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Varney, M. D.

12/14, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Dec 17 1929

20 UNDERTAKER: Wm J Pickney & Son — ADDRESS: N & Pa

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52057

CERTIFICATE OF DEATH

113

E 52057

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl McMahon

(a) RESIDENCE NO. 1013 N Cross ST., 21-29 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Wht.

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Jos Mc Mahon

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz Chaney

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Jos Mc Mahon

(Address) 1013 N Cross St

15 Dec 1 1929 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929, to Dec 15, 1929, that I last saw her alive on Dec 15, 1929 and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Premature Infant

Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. S. Johnson, M. D.

Dec. 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co — DATE OF BURIAL 12-17 1929

20 UNDERTAKER Bernard C. Harke — ADDRESS 1000 S Paca St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52058

CERTIFICATE OF DEATH.

129

E 52058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 749 Mc Cabe ave ST., WARD) 27-48

2-FULL NAME Arianna Conncill

(a) RESIDENCE NO. 749 Mc Cabe ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W Conncill

6 DATE OF BIRTH (month, day, and year) April 18. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0-31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Queen anns co

PARENTS

10 NAME OF FATHER Samuel S parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland Queen anns co

12 MAIDEN NAME OF MOTHER Susan Meredith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant Mable Lee

(Address) 749 Mc Cabe Ave

15

DEC 17 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1929

17

I HEREBY CERTIFY, That I attended deceased from July-18 1926, to Dec. 16 1929.

that I last saw h alive on Dec. 16 1929,

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Hess. M. D.

12.16 1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Dec 19 1929

20 UNDERTAKER Lorenz Lepper

ADDRESS 1 [illegible] North

Spec.—1-10-21—MAT—1500 Blks.

E 52059

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52059

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 W. Mount Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Alvine Lotts 13-50

(a) RESIDENCE NO. 1336 W. Mount Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lotts.

6 DATE OF BIRTH (month, day, and year) March 20-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Schultze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Forster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William C. M-Sue

(Address) Home

15 DEC 7 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 10, 1929, that I last saw h alive on Dec 14, 1929, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

Contributory Cardiac asthma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Edward A. Rochels, M. D.

, 19 (Address) 704 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 18 1929

20 UNDERTAKER Josiah Lester

ADDRESS 1600 W Mount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1

Spec.—1-12-23—M&T—500 Blks.

E 52060 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 122-002 E 52060

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W Balto Jen. Hosp ST., WARD)

2-FULL NAME Mary Jones

(a) RESIDENCE NO. 908 Hilton ST., 16-67 WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	~~Single~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
57 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Benj White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant
(Address)

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/1929

17 I HEREBY CERTIFY, That I attended deceased from 12/5, 1929, to 12/14/1929, that I last saw her alive on 12/14/1929, and that death occurred, on the date stated above, at 8.10 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver (acute)

... (duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? — Clinical sign & autopsy

(Signed) J. F. Castagna

19 ... 19 (Address) W. Balto. Gen. Hospital ... M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 19

20 UNDERTAKER D. Commissioner Health

ADDRESS DEC 17 1929

Per. Chas. E. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 1929 170 ...

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52061

CERTIFICATE OF DEATH

161-001 E 52061

1—PLACE OF DEATH

REGISTERED NO. 14-59

CITY OF BALTIMORE: (No. 2205 Druid Hill St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Bush

(a) RESIDENCE NO. 2205 Druid Hill St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): infant

If married, widowed, or divorced: HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year): Dec 15, 1929

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt, Md.

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Beatrice Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant: Mother

(Address) 2205 Druid Hill

15 Filed DEC 17 1929, 19

C. HAMPSON JONES M.D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to Dec 15, 1929, that I last saw h[illegible] alive on Dec 15, 1929 and that death occurred, on the date stated above, at 10 35 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Georg McDonald M. D.

, 19 (Address) 1019 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 17 1929

Important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 52062 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52062

CERTIFICATE OF DEATH.

161-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 709. S. East ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wright

(a) Residence No. 709. S. East ave St., 26 Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (~~Write the word.~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 12/16/29

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto (State or Country), md

PARENTS.

10-NAME OF FATHER, Bernard C Wright

11-BIRTHPLACE OF FATHER (city or town)..... Balto Md (State or Country),

12-MAIDEN NAME OF MOTHER Anna J Hilleary

13-BIRTHPLACE OF MOTHER (city or town)..... Balto Md (State or Country),

14-

(Informant)..... B C Wright

(Address)..... 709 S. East Ave

JOHNS HOPKINS HOSPITAL

15-

Filed..... 192 C. HAMPSON JONES, M. D. Registrar.

1 71929 DEC 17 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/16/29

17- I HEREBY CERTIFY, That I attended deceased from 12/16/29, 19.. to 12/16/29, 19.., that I last saw h~~e~~ alive on 12/16/29, 19.., and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

Born premature

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pressure on umbilical Cord

(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed)..... M. D.

19 (Address).....

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL..... DATE OF BURIAL, ..., 19....

20-UNDERTAKER, Commissioner Health ADDRESS .....

Per. Wm. E. WOODALL

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52063

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52063

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2623 Pennsylvania Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CHARLES FRANK WOOD. 13-59

(a) RESIDENCE NO. 2623 Pennsylvania Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-7- 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	6	9. 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hotel Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer Rhudes Hotel. Baltimore. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER George W. Wood.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary J. Wood. (Address) 2623 Penna Ave.

15 Filed 1-7 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16-29

17

I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1929, to Dec 15, 1929, that I last saw him alive on Dec 15, 1929, and that death occurred, on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis &
Aortic Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) C. H. Rudegeair, M. D.

Dec 4, 1929 (Address) 550 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	12-18-1929
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 Eutaw Ave.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Mundle

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52064

CERTIFICATE OF DEATH

111-002 E 52064

1-PLACE OF DEATH

City of Baltimore: (No. 2307 Lake Ave St., Ward) 8-45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leopold Mundle

(a) RESIDENCE NO. 2307 Lake Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Kathrina Mundle

6 DATE OF BIRTH (month, day, and year) Nov 11/1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Lord Balto., Hotel

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Mundle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Kathrina Morscher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Wife
(Address) 2307 Lake Ave

15 Filed 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probable Duodenal Ulcer

(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
12/16/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 12/18/1929

20 UNDERTAKER [signature] — ADDRESS 1401 N Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52065

CERTIFICATE OF DEATH

178 E 52065

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4145 Guilford St., Ward)

2-FULL NAME Catherine T. Burns, 12-19

(a) RESIDENCE NO. 440 ~~Putnam~~ Puttman Place St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Burns

6 DATE OF BIRTH (month, day, and year) March 21, 1893

7 AGE Years	Months	Days 25	IF LESS than 1 day ..hrs. or ..min.
36	8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Poehler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah F. Fortman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs Leroy Schmidt,
(Address) 412 E. Twenty Sixth St.

15 Filed ..., 19.. C. HAMPSON JONES M. D. Registrar
71929 By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 16. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest which ~~autopsy~~
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
3rd degree burns and asphyxia due to
smoke
smoke & gas
(duration) ..yrs. ..mos. ..ds.
CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) W. F. Kilby, M. D.
12/17. 1929 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Dec. 18, 1929

20 UNDERTAKER E. Leroy Stiffler, & Sons. — ADDRESS 125 E. North ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52066

CERTIFICATE OF DEATH

129 E 52066

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3rr7 Avon ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond P. Conroy 9-46

(a) RESIDENCE NO. 3rr7 Avon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Brennan Conroy

6 DATE OF BIRTH (month, day, and year): Feb. 17, 1896

7 AGE: Years 33 | Months 9 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Balto. Steel Co.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Stephen Conroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Marie Conroy

(Address) 3rr7 Avon Ave

15 Filed DEC 19 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1928 to Dec 15 1929 that I last saw h alive on Dec 15 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none, unknown

(Signed) Chas Smith, M. D.

Dec 17 1929 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Dec. 18 1929

20 UNDERTAKER: Margaret A. Flynn

ADDRESS: 1417 Light St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

178

E 52067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 445 Guilford Av. St., Ward) 10-14

2-FULL NAME Anna R. Campbell

(a) RESIDENCE NO. 1607 Greenmount Av. St., Ward

(Usual place of abode)

Length of residence in city or town where death occorred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Assorter
(b) General nature of industry, business, or establishment in which employed (or employer) Paper Co
(c) Name of employer Connor Trade Paper Co.

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Schultz

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Elmer Schultz
(Address) 3231 Pridmore

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

DEC 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxia
3rd degree burns, and ~~contusion~~ Shock
(All other causes)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) See memo
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~no~~
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Wm. L. Riley, M. D.
DEC 17 1929 (Address) 1139 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	12/18 1929
20 UNDERTAKER	ADDRESS
E. J. Fanning, Inc.	1388 E. Lafayette

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Baer

E 52068 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52068

CERTIFICATE OF DEATH. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2243 W. Lexington ST., WARD) REGISTERED NO. 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Eliza Baer

(a) RESIDENCE NO. 2243 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Henry Baer

6 DATE OF BIRTH (month, day, and year): August 12th 1848

7 AGE — Years: 81 — Months: 4 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 037

9 BIRTHPLACE (city or town) (State or country): Brookville Montgomery Co Md

PARENTS

10 NAME OF FATHER: William Parsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brookville Montgomery Co Md

12 MAIDEN NAME OF MOTHER: Margaret Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brookville Montgomery Co Md

14 Informant: Arthur E. Baer

(Address): 1201 Rosemont Ave

15 1 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 9th 1929 to Dec 16th 1929, that I last saw her alive on Dec 16th 1929, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Fracture Thigh (Surgical shock)

Accidental fall downstairs on Dec 7th 1929 (duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardio Respiratory Paralysis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) H. H. Clark M. D.

12/16, 1929 (Address) 3552 Chestnut Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 12-19 1929

20 UNDERTAKER: H. H. Cook — ADDRESS: 1211 N Paul St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Lowery 185

E 52069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., Ward)

2-FULL NAME Leroy E. Lowery 6-9

(a) RESIDENCE NO. 1700 E. Balto., St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lilly Lowery

6 DATE OF BIRTH (month, day, and year) May 5/1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	0 7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 015

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jas. F. Lowery

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Tilman Island, Md

12 MAIDEN NAME OF MOTHER
Ada A. James

13 BIRTHPLACE OF MOTHER (city or town) Talbot, Md
(State or country)

14 Informant: James F. Lowery
(Address) 2445 Lauretta Ave

15 Filed 1 7 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Frac Skull-Cerebral Hemorrh ge
Ruptured Spleen & Stomach
Accidentally fell from roof of
3 north Broadway or 1700 E. Balto.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/17 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross R C Cem Md — DATE OF BURIAL Dec 18 1929

20 UNDERTAKER John F Denny — ADDRESS 745 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E-520701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 52070

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., F WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jay Baker (Jessie H Baker) 7-9

(a) RESIDENCE NO. Ladyfriend Rd. (Usual place of abode) Sparrows Pt. ST., 2nd WARD

Length of residence in city or town where death occurred 2 yrs. 2 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mabel Baker

6 DATE OF BIRTH (month, day, and year) Feb 2 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X	26	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil Pumper

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Edgar S. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Ora Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15

Filed 1929 19 Per C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16-29

17

I HEREBY CERTIFY, That I attended deceased from 12-15, 1927, to 12-16, 1929, that I last saw him alive on 12-16, 1929 and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Hedwig Koenig, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL Dec 19 1929

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52071

CERTIFICATE OF DEATH

178

E 52071

REGISTERED NO. 10-15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 443 Guilford Av St., Ward)

2-FULL NAME Elizabeth Wright

(a) RESIDENCE NO. 842 Eutaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wright

6 DATE OF BIRTH (month, day, and year) 11/22/83

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	45		24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) Cloth Factory
(c) Name of employer

9 BIRTHPLACE (city or town) U. S.
(State or country)

PARENTS

10 NAME OF FATHER Jas Donoghue

11 BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Feeney

13 BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

14 Informant Mary Wright
(Address) 842 Eutaw St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Due to Senility
with arteriosclerosis
or Investigation which will be held Dec 20 when I
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) must fix this out

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 443 Guilford Av.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) no T. Riley Cowman, M. D.
Dec 17 1929 (Address) 1629 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	12/18 1929
20 UNDERTAKER	ADDRESS
J. J. Young & Sons	318 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52072

CERTIFICATE OF DEATH

100-001

E 52072

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 917 W 36th St., Ward)

2-FULL NAME Jake Lee Hong.

(a) RESIDENCE NO. 917 W 36th St., 13-52 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charlie Hong

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Cal

12 MAIDEN NAME OF MOTHER Hall Wong.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) China

14 Informant Charlie Hong
(Address) 917 W 36th St

15 Filed 1929 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Hanson Jones, M. D.

12/17 1929 (Address) 963 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Dec 18 1929

20 UNDERTAKER: John O. Mitchell Son ADDRESS: 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

71929

Cor.—10-10-29—A Co.—100 Bks.

E 52073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. Watson 8-40 Ward)

2-FULL NAME Peter Joseph Watson

(a) RESIDENCE NO. 3153 Ravenwood Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Watson

6 DATE OF BIRTH (month, day, and year) Nov 7/1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Goldberg Bros.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New York City

PARENTS

10 NAME OF FATHER Joseph Watson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Nellie Viator

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant William V. Watson (Bro
(Address) 3155 Ravenwood Ave

15 Filed 19 C. HAYDEN JONES, Registrar.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Green, M. D.

12/10/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetary — DATE OF BURIAL 12/19 1929

20 UNDERTAKER Chas R. Kuchauskas — ADDRESS 637 S. Paca St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52074

CERTIFICATE OF DEATH

90 E 52074

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 32-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Brooke Gilpin

(a) RESIDENCE NO. 3333 N Charles St Winchester Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. 15 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Newcomer Gilpin

6 DATE OF BIRTH (month, day, and year) April 3, 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Bernard Gilpin

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bernard

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Hospital Records

(Address)

15 Filed DEC 18 1929 LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17-29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1929, to Dec. 17, 1929 that I last saw h. alive on Dec. 17, 1929 and that death occurred, on the date stated above, at 4½ p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic passive Congestion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) James Arthur Wemberg, M. D.

12/17/1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va.

DATE OF BURIAL DE 18 1929

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Oakland

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52075

CERTIFICATE OF DEATH

86-001

E 52075

1—PLACE OF DEATH Provident Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. 574 Division ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest Braxton

(a) RESIDENCE NO. 1004 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married—

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
-	3	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George Braxton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Gloucester County Va

12 MAIDEN NAME OF MOTHER Maud Harden

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Hanover County Va

14 Informant Maud Braxton
(Address) 1004 McCulloh St

15 Filed DEC 19 1924 HAMILTON JONES, M. D. Registrar

C 1-81929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1924, to Dec. 16, 1924, that I last saw him alive on Dec. 16, 1924, and that death occurred, on the date stated above, at 9:55 a m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ch. Eczema + Otitis Media

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. L. Claytor, M. D.

12/16 1924 (Address) 1000 Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec. 19 1924
20 UNDERTAKER	ADDRESS
Charles H. Alexander	1400 Druid Hill Ave.

Important. For instructions see Order of Certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52076

CERTIFICATE OF DEATH

51 ✓ E 52076

1—PLACE OF DEATH President Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 514 Lemington ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie Parker

(a) RESIDENCE NO. 1705 Ellsworth ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. · How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Schoolgirl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-19-17 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Baltimore Md~~
(State or country) Walchpreague Va

PARENTS

10 NAME OF FATHER Robert Barker

11 BIRTHPLACE OF FATHER (city or town) Walchpreague
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) Walchpreague
(State or country) Va

14 Informant Mary Bailey
(Address) 1705 Ellsworth St

Filed JAN 8 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to Dec 17, 1929, that I last saw her alive on Dec 17, 1929, and that death occurred, on the date stated above, at 3.50 a.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Acute Rheumatic Fever ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J. Carr, Jr M. D.

19 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12/19/1929

20 UNDERTAKER Chas. H. Alexander ADDRESS 1706 Druid Hill

IMPORTANT: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52077

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1606-E. Lafayette St., 8 17 Ward)

2-FULL NAME Charles E. Browning

(a) RESIDENCE NO. 1606 E Lafayette (St.) Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie M. Selby

6 DATE OF BIRTH (month, day, and year) 8/20/1882

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
47	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sykesville
(State or country) Md

PARENTS

10 NAME OF FATHER Everett Browning

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Sarah Thompson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co Md.

14 Informant Mrs Jennie Browning
(Address) 1606-E. Lafayette St

Filed DEC 18 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(History of onset, etc.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos Weiss, M. D.

12/17/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 12/18/29

20 UNDERTAKER George J Puth — ADDRESS 1735 Hoffman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52078

CERTIFICATE OF DEATH.

E 52078

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland ST. 6-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores Kiefner

(a) RESIDENCE NO. 1714 N. Bethel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/29/1924

7 AGE

Years	Months	Days	If LESS than 1 day hrs. or min.
5	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Kiefner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Wilhelmina Beraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Kiefner

(Address) 1714 N. Bethel St

15 Filed DEC 18 1929 C. HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-30, 1929, to 12-16, 1929, that I last saw h alive on 12-16, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Tricuspid and pulmonic Stenosis)

(duration) 5 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? congenital

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) A. B. Sibrt M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL 12/19/29

20 UNDERTAKER Geo. D. Rutty & Co ADDRESS 1735 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52079

CERTIFICATE OF DEATH.

129 E 52079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital WARD 27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Pirozzi

(a) RESIDENCE NO. 2705 Eutaw Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Pirozzi

6 DATE OF BIRTH (month, day, and year) 11/9/1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
67	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Raffaele Pirozzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Gelsamino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Raffaele Pirozzi

(Address) 2705 Eutaw Ave

15 Filed ..., 19... HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 15, 1929, that I last saw h[illegible] alive on Dec 15, 1929, and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos da.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W Hendrix M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 12/18 1929

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 52080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52080

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 550 Mosher St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda M Symms

(a) RESIDENCE NO. 550 Mosher St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — John Symms

6 DATE OF BIRTH (month, day and year): Oct 25 1881

7 AGE: 48 Years 1 Months 24 Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va

PARENTS

10 NAME OF FATHER: Leander Grm

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Cecelia Grumbey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: John Symms

(Address): 550 Mosher St

15 Filed DEC 18 1929

C. HAMILTON JONES, M. D. Registrar

By Rly.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: December 16- 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929 to Dec 16, 1929, that I last saw h... alive on Dec 16, 1929 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

Arteriosclerosis

2 yrs (duration)

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F Chaney M. D.

19 29 (Address) 1501 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Valley

Date of Burial: 12-19 1929

20 UNDERTAKER: Geo T. A. Gibson

ADDRESS 1738 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52081

CERTIFICATE OF DEATH.

4-E 52081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith St. 10-14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. M. Richardine Nichols

(a) RESIDENCE NO. Convent of Notre Dame ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer Notre Dame Convent

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Corley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant School Sisters of Notre Dame
(Address)

15 Filed DEC 16 1929 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Dec 17, 1929, that I last saw her alive on Dec 16, 1929, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma
Stomach
(duration) yrs. 10 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) J. J. Kirby M. D.

12/17, 1929 (Address) 1106 Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Mod. | DATE OF BURIAL Dec 19 1929

20 UNDERTAKER Frank A. Fink | ADDRESS 910 W. Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—10 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52082

CERTIFICATE OF DEATH

101-001

E 52082

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 604 Watemeyer St., 14-20 Ward)

2-FULL NAME Ogluria Simms

(a) RESIDENCE NO. 604 Watemeyer St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fm

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: M

6 DATE OF BIRTH (month, day, and year): Sept 2 1929

7 AGE: Years 0 Months 3 Days 15 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Thos Simms.

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country): Md

12 MAIDEN NAME OF MOTHER: Clara Coates

13 BIRTHPLACE OF MOTHER (city or town): Balto Co
(State or country): Md

14 Informant: Clara Simms
(Address): 604 Watemeyer

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

C 1 81929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Heflich M. D.

19 (Address) Govans

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge Md — DATE OF BURIAL: Dec 18th 19 29

20 UNDERTAKER: A. Jones — ADDRESS: W. St. Gile

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 52083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

123 E 52083

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hospital (Ward) 9-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Judelwitz

(a) RESIDENCE NO. 950 N. Washington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4/ yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 4/ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Judelwitz

6 DATE OF BIRTH (month, day, and year) Oct. 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56	2	(2)	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Sidle

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Frances Sidle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hospital Records

(Address)

12-8-1929 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/5 1929, to 12/18 1929, that I last saw her alive on 12/15 1929, and that death occurred, on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:

Empyema of gall-bladder with lithiasis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 12/13

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. A. Hampton M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — Date of Burial 12/18 1929

20 UNDERTAKER Jack Levin — ADDRESS 1439 E Balt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 52084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 52084

1-PLACE OF DEATH

REGISTERED NO. 24231

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1012 S. Fremont Ave ST. 24? WARD)

2-FULL NAME Drene Chambers

(a) RESIDENCE No. 1012 S. Fremont Ave ST., 24? WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of: William Chambers

6 DATE OF BIRTH (month, day, and year): June 1 1867

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of Industry, business, or establishment in which employed (or employer): House wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): An Arundel Co, Md.

PARENTS

10 NAME OF FATHER: Samuel Calbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): An Arun del Co, Md.

12 MAIDEN NAME OF MOTHER: Rachel Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): An Arun del Co Md.

14 Informant: John Simmons

(Address): 1012 S. Fremont Ave

15 Date: 8-1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/15/ 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/10/, 1929, to 12/15/, 1929, that I last saw her alive on 12/14/, 1929, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis; Acute Dilatation.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Carcinoma of Cervix

(duration) yrs. 4 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical + History

(Signed) W. W. Bishop, M. D.

, 19 (Address) 709 Druid Pk. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md

DATE OF BURIAL: Dec 18 1929

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1745 Eastland Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52085

CERTIFICATE OF DEATH

90 ✓

E 52085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1632 Warwick St., 16-68 (Ward)

2-FULL NAME Leah Richter

(a) RESIDENCE NO. 1632 Warwick St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 82 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Austria
(State or country)

PARENTS

10 NAME OF FATHER: Edwin Richter

11 BIRTHPLACE OF FATHER (city or town): Austria
(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Gottlieb

13 BIRTHPLACE OF MOTHER (city or town): Austria
(State or country)

14 Informant: Flora Hymson
(Address): 1632 Warwick

15 Filed 19 [illegible] JONES, M. D.
Registrar

OCT 8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Klein, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 10/10 19 29

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52086

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

CERTIFICATE OF DEATH

E 52086

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 27-30 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward J. Martin

(a) RESIDENCE NO. 302 Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinsmith Odd

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?

(State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Ireland

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed 19 C. HAMPTON JONES, M.D.

Registrar

C 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-29

17 I HEREBY CERTIFY, That I attended deceased from 6-23, 19 24, to 12-14, 19 29,

that I last saw h.im alive on 12-14, 19 29

and that death occurred, on the date stated above, at 7 00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

over 5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Hypertension

over 5 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. & P.E.

(Signed) Marvin M. McLean, M. D.

12-14, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	DEC 18 1929

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52087
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

178 ✓ E 52087
REGISTERED NO.

City of BALTIMORE: (No. Mercy Hosp St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonina Beier

(a) RESIDENCE NO. 633 S. Montford Ave St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 31 1875

7 AGE: Years 53 Months 11 Days 16 15 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paper factory
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Thomas B. O'Connor

9 BIRTHPLACE (city or town): Poland
(State or country)

PARENTS

10 NAME OF FATHER: Laurina Kondyski

11 BIRTHPLACE OF FATHER (city or town): Poland
(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Poland
(State or country)

14 Informant: Helen Minciskowska
(Address) 633 S. Montford Ave

15 Filed....., 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16 - 25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Im. Burns.

(duration) 5m yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. F. Roby Coroner M. D.

Dec. 17, 19 25 (Address) 163 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. Date of Burial 12/19 1925

20 UNDERTAKER: Stephen J. Fealbrook ADDRESS 1000 S. Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52088

CERTIFICATE OF DEATH

100-001

E 52088

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 425 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adaline Walls

(a) RESIDENCE NO. 301 N. Green St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Walls

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Edith Rouser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Mr. Geo. Walls
(Address) 301 N. Green St

15 Filed DEC 18 1929 16 C. HAMPSON JONES, M. D., Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17- 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 301 N. Green St

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Gilbert M. D.

12-18-1929 (Address) 2136 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Dec 18 1929
20 UNDERTAKER	ADDRESS
H W Routson	223 S. Wolfe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52089

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 97-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Parrott

(a) RESIDENCE NO. 5504 Arabia Ave., ST., Hamilton, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 25, 1889.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	40	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Parrott

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Mary Fitzgibbons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address)

15 Filed DEC 1 1929 E. L. Moon JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18/29.

17

I HEREBY CERTIFY, That I attended deceased from 12/11, 1929, to 12/18, 1929, that I last saw him alive on 12/18, 1929 and that death occurred, on the date stated above, at 1.05 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Septicemia Bedsores

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Rudolph Wilmoth, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 12/20/1929

20 UNDERTAKER Robt. J. Turner

ADDRESS 1401 N Broadway

Spec.—1-10-21—M&T—1500 Blks.

E 52090 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 52090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 N Lanvale ST.) (WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Estelle Friesel

(a) RESIDENCE No. 2544 N Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frederick Friesel

6 DATE OF BIRTH (month, day, and year): Oct 16 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John D Angerd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann M Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. E. E. Cole

(Address) 2544 N Lanvale St

15 Filed DEC 19 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 17, 1929, that I last saw h[illegible] alive on Dec 17, 1929, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arteriosclerosis Congestion of

Lung - Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norbert C Nebel, M. D.

Dec 17 1929 (Address) 2150 Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 20 1929

20 UNDERTAKER: George J Smith — ADDRESS 19[illegible] Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 V

E 52091
1—PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. E 52091

CITY OF BALTIMORE: (No. 5313 Reisterstown Rd ST. 27-55 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl Leroy Mallery

(a) RESIDENCE NO. 5313 Reisterstown Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys G. Mallery

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas & Electric Co.

9 BIRTHPLACE (city or town) Plainsfield
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George B. Mallery

11 BIRTHPLACE OF FATHER (city or town) Plainsfield
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Julia Walker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Earl Mallery
(Address) 5313 Reisterstown Road

15 Filed 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4th, 1929, to Dec 14, 1929, that I last saw him alive on Dec. 14, 1929, and that death occurred, on the date stated above, at 12.40 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Started as a common Sore throat. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. W. Keown, M. D.

Dec 17 1929 (Address) 1938 Linden Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec. 18 19 29

20 UNDERTAKER Peter D. Cook. ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 52092

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1931 Hollins St., 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Blanch

(a) RESIDENCE NO. 1931 Hollins St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Homer J. Blanch

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Fleming

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Drexel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Homer J. Blanch
(Address) 1931 Hollins St.

15 Filed DEC 16 1929 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 2- 1929 to Dec 17 1929

that I last saw her alive on Dec 17 1929

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hist of Stomach

(Signed) Chas A Carlson, M. D.

12/17 1929 (Address) 2105 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec. 20 1929
UNDERTAKER Joseph S Cook	ADDRESS 1003 West Baltimore St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52093

CERTIFICATE OF DEATH

90

E 52093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE; (No.) 5408 Denmore ST. 27-55 (WARD)

2—FULL NAME Mary Neal

(a) RESIDENCE NO. 5408 Denmore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced: ~~Husband of~~ (or) WIFE of: Wm L. Neal

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: George Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sarah Young

(Address) 5408 Denmore

15 Filed 19 C. HARRISON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 17 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th 1929, to Dec 17th 1929

that I last saw her alive on Dec 17, 1929

and that death occurred, on the date stated above, at 2.00 A. m.

The CAUSE OF DEATH* was as follows: Chr. Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Geo. H. Langenbach, M. D.

Dec 18, 1929 (Address) 225 N. Wolfe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — DATE OF BURIAL: Dec 18 29

20 UNDERTAKER: Samuel Wesley — ADDRESS: Cambridge Md

Spec.—2-29-28—L. F. S.—500 Blks.

232134 E 52094

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

CERTIFICATE OF DEATH

REGISTERED NO. E 52094

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rodney Smedley

(a) RESIDENCE NO. 1942 W - Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/ /29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER James Smedley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Agnes Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa -

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 18 1929, 19 HAMILTON JONES, M. D. Registrar

C 1 6198

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14-29

17

I HEREBY CERTIFY, That I attended deceased from December 14, 1929, to Dec 14, 1929,

that I last saw him alive on Dec 14, 1929

and that death occurred, on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Birth injury

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Benj. E. Dodge, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 18 1929

Commissioner Health

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52095

CERTIFICATE OF DEATH

45 E 52095

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 7 8-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Hogan

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer: Mt Hope Retreat

9 BIRTHPLACE (city or town) (State or country): Boston. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Mt Hope Friends

(Address): Mt Hope Retreat

15 1 8 1929, 19 HAMPSON JONES 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16-1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Dec 16, 1929, that I last saw h[illegible] alive on Dec 16, 1929, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Intestines

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Depression Psychosis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Mullin P. Bell M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hope Cemetery

DATE OF BURIAL: 12/19 1929

20 UNDERTAKER: Chas. P. Grand Son

ADDRESS: 1180 W. Royal Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52096

CERTIFICATE OF DEATH

57

E 52096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 831 S. Ellwood ave ST., 1-1 WARD)

2—FULL NAME Anna Barron

(a) RESIDENCE NO. 831 S. Ellwood ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July 3, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	5	11 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Richard Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Feirney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Barron

(Address) 831 S. Ellwood ave

15 DEC 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 16'29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1929, to Dec. 16, 1929.

that I last saw h.er alive on Dec. 16, 1929

and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chr.

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. C. Lipsey, M. D.

, 19 (Address) 43 S. Patterson Pk Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec. 19, 1929

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Balto St.

Spec.—1-12-23—M&T—500 Blks.

E 52097 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 52097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 4005 Chesley Ave., Overlea ST. 27-42 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES H. SCHROEPFER

(a) RESIDENCE No. 4005 Chesley Ave., Overlea ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 25, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer 886

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Schroepfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Kirchner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Walter Rudolph (Address) 4005 Chesley Avenue.

15 Filed 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18th, 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Dec 18, 1929, that I last saw h live on Dec 17, 1929 and that death occurred, on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 17 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Asthenia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Edwin K. Ballard, M. D.

(Address) 1622 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Dec 20, 1929

20 UNDERTAKER Frederick Lassahn Sons — ADDRESS Fullerton, Md.

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52098 +90 E 52098

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. St. Joseph's Hospital St., 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Erlanger

(a) RESIDENCE NO. 27 Brightside Ave. Pikesville Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pauline Cans Erlanger

6 DATE OF BIRTH (month, day, and year) Feby. 26th. 1886.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	43	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrical.
(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor.
(c) Name of employer

9 BIRTHPLACE (city or town) East Liverpool
(State or country) Ohio. England.

PARENTS

10 NAME OF FATHER William Erlanger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Meyers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Rabbi M. S. Lazaron
(Address) Naylor Lane.

15 Filed C. HAMPSON JONES, M. D. Registrar
By

1 8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17th. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to n/s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History of Angina.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Callen, M. D.

2/15/29 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	12/19/ 1929

20 UNDERTAKER Maid Sondheim ADDRESS 115 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52099

CERTIFICATE OF DEATH

199 E 52099

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 2-37 Ward)

2-FULL NAME Charles A. Willemen

(a) RESIDENCE NO. 5117 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Willemen

6 DATE OF BIRTH (month, day, and year) Oct 6 — 1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	85	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Thos Willemen

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Mrs Caroline Motswell
(Address) 5117 Eastern Ave

DEC 18 1929

C. HAMPSON JONES
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Broncho Pneumonia - with an association of 3 Fract Ribs left with Empyema - also Cerebral Hemorrhage Struck & Knocked down by Auto Driven by Negro

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Fairview Pk Rd

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. Hance M. D.

12/18 1929 (Address) 2939 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 12/19 1929

20 UNDERTAKER J. H. Cook — ADDRESS 2174 E Pratt St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52100

CERTIFICATE OF DEATH

90 E 52100

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1005 Appleton St. 16 Ward)

2-FULL NAME Amelia T. Urbach

(a) RESIDENCE NO. 1005 Appleton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Urbach

6 DATE OF BIRTH (month, day, and year): May 24. 1849

7 AGE: Years 80 | Months 6 | Days 23 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: A. Stone

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER: Louis Dorr

11 BIRTHPLACE OF FATHER (city or town): Unknown
(State or country)

12 MAIDEN NAME OF MOTHER: Pauline Harge

13 BIRTHPLACE OF MOTHER (city or town): Unknown
(State or country)

14 Informant: Mrs. William Parsons
(Address) 1005 Appleton St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

12-17 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: 12/20 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 81929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52101

CERTIFICATE OF DEATH

E 52101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 580 Greenmount St. 17-21 Ward)

2-FULL NAME Edna Jones

(a) RESIDENCE NO. 580 Greenmount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Senin Jones

6 DATE OF BIRTH (month, day, and year) Nov 19-1892

7 AGE	Years	Months	Days	IF LESS than I day hrs. or min.
	37	1	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Harris

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Hager

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Senin Jones
(Address) 580 Greenmount

15 Filed C. HAMPSON JONES, M. D.
Registrar

8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 17th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H. Lee Smith, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Dec 21 1929

20 UNDERTAKER Harry W Chase Son

ADDRESS 1400 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52102

CERTIFICATE OF DEATH

90 E 52102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 904 Argyle Ave St., 17-24 Ward)

2-FULL NAME Laura Holliday.

(a) RESIDENCE NO. 904 Argyle St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 Sex	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Ohl
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hy. F. Dutton
(Address) 1536 Argyle Ave

15 Filed 1929 C. HAMPSON JONES, M. D., Registrar. By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. Colin Kerr, M. D.
June 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn (Cem) | DATE OF BURIAL Dec 20 1929

20 UNDERTAKER Sam'l H Case & Son | ADDRESS 1400 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52103

CERTIFICATE OF DEATH

129 E 52103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1227 Laurens St. 14-20 Ward)

2-FULL NAME Geo. B. Gray.

(a) RESIDENCE NO. 1227 Laurens. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race Col | 5 Single, Married, Widowed or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years 53 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Lottie Gray
(Address) 1227 Laurens

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to [redacted] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [redacted] M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glendale Md	Dec 20 1929
20 UNDERTAKER Chas. H. Chase & Sons	ADDRESS 1400 Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPAT... very important. See instructions on back of certificate.

1 8 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 52104

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52104

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 E. Madison ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy Virginia Cooper

(a) RESIDENCE NO. 1526 E Madison ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elliott Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Virginia M. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Martha Young
(Address)

15 Filed DEC 18 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Dec 14, 1929, that I last saw her alive on Dec 14, 1929 and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Bronchial Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough,

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. A. Hamburger, M. D.

12/17, 19 29 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	12-19 1929
20 UNDERTAKER	ADDRESS
Mrs Chas G. Bailey	1421 Jefferson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52105

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 52105

1—PLACE OF DEATH

CITY OF BALTIMORE; (No.) 920 W. Mulberry St., (WARD) 18-N

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Lee Howard

(a) RESIDENCE NO. 920 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) B & O.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Elmora Banks

(Address) 920 W. Mulberry St

15 Filed DEC 19 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 17, 1929, that I last saw him alive on Dec 17, 1929, and that death occurred, on the date stated above, at 9:55 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm A Casey, M. D.

, 19 (Address) 103 Garrett

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 12-20 1929

20 UNDERTAKER John N. Joachim

ADDRESS 1027 Hand Hill

Spec.—2-29-28—L. F. S.—500 Blks.

Hauenstein

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52106

CERTIFICATE OF DEATH

90 ✓ E 52106

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ——— ST. 20-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Huenstein

(a) RESIDENCE NO. 356 Smallwood ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. — mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 17th 1880 (or Duration)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman. 0/8

(b) General nature of industry, business, or establishment in which employed (or employer) Street railway

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Huenstein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Records Dept.
(Address) BALTIMORE CITY HOSPITALS

15 Filed DEC 19 1929 H. Mackey JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1929, to Dec. 18, 1929, that I last saw h[illegible] alive on Dec 18, 1929 and that death occurred, on the date stated above, at 7:25 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis. chronic and acute.

(duration) over 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Alcoholism. chronic and acute unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History; clinical exam.

(Signed) Warren T. McCleary M. D.
BALTIMORE CITY HOSPITALS

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 12/20/1929

20 UNDERTAKER E. D. Kephart — ADDRESS 1150 W. Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

126 E 52107

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 8-40

CITY OF BALTIMORE: (No. 33rd & Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Pueschel

(a) RESIDENCE NO. 3401 Ravenswood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 14 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert J. Pueschel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ines M. Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Albert Pueschel.
(Address) 3401 Ravenswood Ave.

15 Filed C 19 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16/1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 16, 1929

that I last saw h[illegible] alive on Dec 16, 1929

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis (diffuse - probably pneumococcus)

(duration) yrs. mos. 14 ds. +

CONTRIBUTORY (Secondary) Malnutrition, dehydration + secondary anemia, (duration) yrs. mos. 14 ds. +

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. L. Swarts Wilder, M. D.

12/19/1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 12/19/1929

20 UNDERTAKER: H. A. Wippirt — ADDRESS: 1850 N. Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

E 52108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 E 52108

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) 30-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Bock

(a) RESIDENCE NO. 2102 Wilkens ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 7 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) May 10 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Bock

11 BIRTHPLACE OF FATHER (city or town) ~~Baltimore~~ Rockwell Bromgery (State or country)

12 MAIDEN NAME OF MOTHER Unknown Bertha Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Hospital Records

(Address)

15 Filed 1 9 1929 H. A. SON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 25, 19 29, to Dec. 18, 19 29, that I last saw her alive on Dec. 18, 19 29 and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tubercu losis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thrower M. D.

12-18 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 12/21/1929

20 UNDERTAKER F. D. Kilpatrick — ADDRESS 1850 N. Bond St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52109 E 52109

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Hebrew Aged Home.

CITY OF BALTIMORE: (No. Belvidere & Greenspring Ave. St., 17 WARD) REGISTERED NO. 54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Goodman

(a) RESIDENCE NO. Belvidere & Greenspring Ave. St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer ..

9 BIRTHPLACE (city or town) Courland, Russia (State or country)

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sigmund Friedland Supt (Address) Hebrew Home for Aged.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec 18, 1929, that I last saw her alive on Dec 18, 1929 and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Hebrew Home for Aged

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Edmund Levin, M. D.

12/18 1929 (Address) 2037 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Rd — DATE OF BURIAL 12/19 1929

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Baltimore St

TION is very important See instructions on back of certificates.

C 1 1929

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52110

CERTIFICATE OF DEATH

74-001

E 52110

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4712 Roland Ave. (ST.) 27-53 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joanna W. Merritt

(a) RESIDENCE NO. 4712 Roland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Merritt

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John P. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER --- McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Eliz. M. Lowe

(Address) 4712 Roland Ave.

15 Filed [illegible] 19 [illegible] Registrar

C 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18- 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec. 18, 1929, that I last saw h[illegible] alive on Dec. 18, 1929 and that death occurred, on the date stated above, at 7-15P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Right Hemiplegia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Arteria Sclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Coma Paralysis

(Signed) M. Gibson Forlines, M. D.

12/19 1929 (Address) 4822 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton, Md.	Dec. 21, 19 29

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mitchell & Mitchell

Spec.—8-16-29—L. F. S.—100 Bks.

Lotta. Kettlewell.

E 52111

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52111

CERTIFICATE OF DEATH

90

12-50

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2735 Guilford Ave. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lotta. Kettelwell.

(a) RESIDENCE NO. 2735 Guilford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) June 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Haller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Charlotta ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Grace H. Kettlewell

(Address) 2735 Guilford Ave.

15 Filed C 19 1929 H. Fox JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18-1929

17 I HEREBY CERTIFY That I attended deceased from June 20, 1929, to December 18, 1929, that I last saw h alive on December 18, 1929 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Lung Condition

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Pulmonary Edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Robert L. Kettelwell, M. D.

12/19, 1929 (Address) 2112 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec. 20, 29

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mabbon B. Mitchell

Spec—12-23-21—E.B.R.S.—400 Blks.

E 52112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 52112

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 106 W. University Parkway St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Deaning Walker

(a) Residence No. 106 W. University Parkway St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Francis B. Walker

6-DATE OF BIRTH (month, day and year) Sept 10, 1860

7-AGE, 69 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. or. mts.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Salesman of

(b) General nature of industry, business, or establishment in which employed (or employer). varnish (b)

(c) Name of employer.

9-BIRTHPLACE (city or town). Philadelphia (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, John Walker

11-BIRTHPLACE OF FATHER (city or town) Philadelphia (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Jane Wamsley

13-BIRTHPLACE OF MOTHER (city or town). Ireland (State or Country).

14-

(Informant) Mrs. Francis B. Walker

(Address) 106 W. University Parkway

15-

Filed DEC 19 1929 By C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 18, 1929

17- I HEREBY CERTIFY, That I attended deceased from May 1st, 1927 to Dec 18, 1929

that I last saw him alive on Dec 18, 1929

and that death occurred, on the date stated above, at 9 A.P. m.

The CAUSE OF DEATH* was as follows:

cerebral arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemmorhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George A. Kemp M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Philadelphia, Pa.	Dec. 21, 1929
20-UNDERTAKER.	ADDRESS
John O. Mitchell & Sons	1900 Eutaw Pl

Walton B. Mitchell

Instructions on back of certificate.

Spec.—6-9-13—H. P. Co.—1000 Bks.

E 52113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 52113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3907 Garrison Blvd ST. 15-23 WARD?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H Burton

(a) RESIDENCE. No. 3907 Garrison Blvd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 99 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret M Burton

6 DATE OF BIRTH (month, day, and year): Sept 1-1841

7 AGE — Years: 88 Months: 3 Days: 16 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Isaac Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Keturah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Margaret M Burton (Address) 3907 Garrison Blvd

15 Filed ... 19 HAMPTON JONES, M.D. Registrar.

19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 17, 1929, that I last saw h[illegible] alive on 11 " 1929, and that death occurred, on the date stated above, at 110 P m.

The CAUSE OF DEATH* was as follows: Degeneration of Heart Muscles

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Bleaen, M. D.

12/19/1929 (Address) 3907 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burtonsville Md. DATE OF BURIAL: Dec. 20 1929

20 UNDERTAKER: Wm E. Black ADDRESS: 927 N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52114

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 E 52114

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2314 Fleet St. ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lukasz Gmurek

(a) RESIDENCE NO. 2314 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jozefa Gmurek

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper Works

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Paul Gmurek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Orlowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jozefa Gmurek Wife

(Address) 2314 Fleet St

15 Filed DEC 19 1929, 19 H. [illegible] JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17-29

17 I HEREBY CERTIFY, That I attended deceased from 12/14, 1929, to 12/16, 1929, that I last saw him alive on ., 19., and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Krukus M. D.

12/18, 1929 (Address) 918 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Dec. 20. 1929

20 UNDERTAKER: K. Bazewski

ADDRESS: 1930 Eastern Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52115

CERTIFICATE OF DEATH

74-001

E 52115

1—PLACE OF DEATH

REGISTERED NO. 15-58

CITY OF BALTIMORE: (No. 2712 Reisterstown Rd. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice R. Downs

(a) RESIDENCE NO. 2712 Reisterstown Rd ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Grant Downs

6 DATE OF BIRTH (month, day, and year) July 29-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna -

PARENTS

10 NAME OF FATHER Reuel Musselman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Virginia Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Grant Downs
(Address) 2712 Reisterstown Rd.

15 Filed DEC 19 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan — 19 29 to Dec-17th 19 29

that I last saw h alive on Dec-17 1929

and that death occurred, on the date stated above, at 11 00 P m.

The CAUSE OF DEATH* was as follows:

Dec-10th 29 Cerebral Hemorrhage - Paralysis Obesity + Arterio Sclerosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visible

(Signed) O. Bruce Jones, M. D.

19 (Address) 2802 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cem.	Dec. 20 1929
20 UNDERTAKER Harry W. Ellen	ADDRESS 1900 W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52116

CERTIFICATE OF DEATH

167-001

E 52116

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 3216 Elliott St., 16-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Halusty Lonicl

(a) RESIDENCE NO. 3216 Elliott St.,

(Usual place of abode) Ward

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Khmiel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Katerina Wolna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Mrs. Rychwalska
(Address) 1119 S. Bond St.

15 Filed DEC 19 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning Ill.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Evidence

(Signed) G. L. McCabe, M. D.

(Address) 1436 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL Dec 19 1929

UNDERTAKER Wm. S. Fiaczkowski

ADDRESS 1020 S. Kenwood

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52117

CERTIFICATE OF DEATH

89 ✓ E 52117

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3304 White Ave ST. 27 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie C. Wilms

(a) RESIDENCE NO. 3304 White Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman F Wilms

6 DATE OF BIRTH (month, day, and year) Sept 9. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliza Eberly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Herman F Wilms

(Address) 3304 White Ave.

15 FILED DEC 19 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929 to Dec 17, 1929 that I last saw h.er alive on Dec 17, 1929 and that death occurred, on the date stated above, at 10 05 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Obstruction (Angina Sine dolore)

attacks at intervals for 20 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Arteris-Sclerosis a number of years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

12/18. 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Pk.

DATE OF BURIAL Dec 20 1929

20 UNDERTAKER E Louis Heiman

ADDRESS 32 S. Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 52118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52118

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Callow ave ST. 12-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham G. Bronstein

(a) RESIDENCE NO. 2104 Callow Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Brina Bronstein

6 DATE OF BIRTH (month, day, and year): Dec 1859

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Hirsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Zelda —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Balto St

15 Filed ... 1929. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/8/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Dec 3, 1929, that I last saw h... alive on Dec 3, 1929, and that death occurred, on the date stated above, at 12 ... m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary): arteriosclerosis

(duration) ... yrs. 10 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

12/8 1929 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 12/9 1929

UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

Spec.—1-12-28—M&T—500 Blks.

E 52119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ E 52119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew aged Home 24-54 ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Glushakow

(a) RESIDENCE No. Belvedere & Greenspring ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob L. Glushakow

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 60; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old age

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Baltimore St

15 Filed Dec 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec - 18 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1929, to Dec. 18, 1929.

that I last saw he alive on Dec - 15 - 1929

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary sis

(Signed) Herman Siskin, M. D.

12/18, 1929 (Address) 1404 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL 12/19, 1929

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E Balto St

IMPORTANT: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52120

CERTIFICATE OF DEATH

49 ✓ E 52120

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. 26434

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Eaton Ave ST. (WARD)

2-FULL NAME Christopher Bracken

(a) RESIDENCE NO. 3322 E Baltimore St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Feb 4 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer): 063

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John F Bracken

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Mamie Toner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14

Informant: Annie T. Bacus

(Address) 3811 Belair Road

15 Filed DEC 19 1929 HARRY JONES, M. D. Registrar

Rec

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1929, to Dec. 18, 1929, that I last saw him alive on Dec. 18, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of naso-pharynx

(duration) 3 (?) yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis to brain (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of ?

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 21 1929

20 UNDERTAKER: Frank V. Pepitone — ADDRESS: 2818 E. Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

Dr H. Coonan 1001 Aisquith St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52121

CERTIFICATE OF DEATH

90 E 52121

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3425 Lyndale Ave ST. 8-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles R. Brown Jr.

(a) RESIDENCE NO. 3425 Lyndale Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle M. Brown

6 DATE OF BIRTH (month, day, and year) July 31, 19[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	17 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motion Picture Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminister Md.

PARENTS

10 NAME OF FATHER Charles R. Brown Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminister, Md.

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) don't know

14 Informant Myrtle M. Brown

(Address) 3425 Lyndale Ave

15 FILED DEC 9 1929 LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1929, to Dec 17th, 1929, that I last saw h[illegible] alive on Dec 17, 1929 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio-Valvular Disease

Myocardial Insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Herman H. Coonan, M. D.

, 19 (Address) 1001 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	Dec 20 1929
20 UNDERTAKER	ADDRESS
George W. Zinkler	1737 E. Eagu[illegible]

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52122 — 29 — E 52122

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Gilmor ST., 1st WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Digristine

(a) RESIDENCE No. 112 S. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Digristine

6 DATE OF BIRTH (month, day, and year) Nov 3rd 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	..	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Fruit business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Digristine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Philip Digristine

(Address) 112 S. Gilmor st

15 12/20/1929 C. H. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1929 to Dec 17 1929.

that I last saw him alive on Dec 17 1929.

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 11 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

12/18/29 (Address) 1729 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Pleasant 12/20/29

20 UNDERTAKER — ADDRESS

A. Jones 114 S Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of DISEASE TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 52123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 ✓ E 52123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 788 Sarah Ann St. (or Ward)

2-FULL NAME Mamie Smith

(a) RESIDENCE NO. 788 Sarah Ann St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mamie Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address)

15 Filed 417 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene Feller M. D.
(Coroner)

12 17 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial DEC 19 1929

UNDERTAKER Commissioner of Health.

ADDRESS

Per Wm. H. MARSHALL

THE MORGUE.

DEC 13 1929

If any part is illegible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52124

E 52124

1-PLACE OF DEATH Thomas Bascher

City of Baltimore: (No. St. Joseph Hospital St. 4-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Bascher

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 1053 Aisquith St
(c) Name of employer for one hour

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Police Depart.
(Address)

15 Filed 4178 Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/17/29 (Address) 103 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: NS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Coroner's Health. — ADDRESS DEC 19 1929

DEC 19 1929

DEC 18 1929 [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Cc.—100 Bls.

E 52125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Lying Hospital St., 5-8 Ward)

2-FULL NAME Simmons Phillip

(a) RESIDENCE NO. 4 N Front St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Not Known

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer Lay

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

Filed DEC 19 1929 JOHNS M. O. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4 N Front

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Inquest Autopsy

(Signed) [illegible], M. D.

. 19 (Address) 1330 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER (Commissioner of Health)

ADDRESS DEC 19 1929

E. WOODALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52126

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 E 52126

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1-42 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Arthur (Leona) Rossiter Leona F. Rossiter

(a) RESIDENCE NO. 6129 Ridgeview Ave ST. Belair Rd WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Rossiter

6 DATE OF BIRTH (month, day, and year) Nov. 29. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Joseph Potts

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Weber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa

14 Informant Mrs. Arthur Rossiter
(Address) 6129 Ridgeview Avenue

15 Filed 12/19, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17. 1929

17 I HEREBY CERTIFY, That I attended deceased from November 13 1929, to Dec 17, 1929, that I last saw h&y alive on Dec. 17, 1929 and that death occurred, on the date stated above, at 1.35 P.m.

The CAUSE OF DEATH* was as follows:

Hypertherpardium

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & auricular fibrillation (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of Dec. 14

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

12/17, 1929 (Signed) Jesse S. Fiser, M. D.
(Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loud Ridge Cem.	Dec 20, 1929
20 UNDERTAKER Joseph Cook	ADDRESS 603 Park Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52127

CERTIFICATE OF DEATH

E 52127

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles M. Harman

(a) RESIDENCE NO. Elkridge, Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 17 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co (State or country) Md

PARENTS

10 NAME OF FATHER Philip H. Harman

11 BIRTHPLACE OF FATHER (city or town) A.A. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Buckingham

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md.

14 Informant Mrs. Geo. P. Harman

(Address) Elkridge Md.

15 Filed 1 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1929, to Dec. 17, 1929, that I last saw him alive on Dec. 17, 1929 and that death occurred, on the date stated above, at 10 55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bi lateral Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 11, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

Dec. 17 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL A.A. Co. Md

DATE OF BURIAL Dec. 20 1929

20 UNDERTAKER Wm. Fluckner Sons

ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Blks.

E 52128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 52128

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1715 Clevelyn ST., 8-16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Stokes

(a) RESIDENCE NO. 1715 Clevelyn ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	c	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7. 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg
(State or country) Va.

PARENTS

10 NAME OF FATHER Samuel Stokes

11 BIRTHPLACE OF FATHER (city or town) Petersburg
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Bonsell

13 BIRTHPLACE OF MOTHER (city or town) Petersburg
(State or country) Va.

14

Informant Samuel Stokes

(Address) 1715 Clevelyn

Filed 1 9 1929 G. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19. 29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1929, to Dec. 19, 1929, that I last saw h.. alive on Dec. 19, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Wm. L Roy Berry, M. D.

, 19 (Address) 1420 E Clare

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	Dec 21/1929
20 UNDERTAKER	ADDRESS
A. R. Robert Williams	1515 N. Eden Alley

Cor.—10-10-29—A Co.—100 Bks.

E 52129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 188-203 E 52129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Kirk Hosp St 4-30 Ward)

2-FULL NAME Albert Nicholas

(a) RESIDENCE NO. Laurel Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Frank Nicholas

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Anna Foster
(Address) Laurel Md

1 9 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Bronchopneumonia
Gunshot Through wound skull
Struck in a collision
&c

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Laurel Washington Rd

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H Frame M. D.

12/19 1929 (Address) 2939 W Eldern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

DATE OF BURIAL Dec 20 1929

20 UNDERTAKER L Loyd Kaiser

ADDRESS Laurel Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 52130

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4606 Glenarm Ave. St. ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO. ...

2-FULL NAME John Nagy

(a) RESIDENCE No. 4606 Glenarm Ave. St., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Nagy

6 DATE OF BIRTH (month, day, and year) April 16th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Can Co.

9 BIRTHPLACE (city or town) ... (State or country) Hungary

PARENTS

10 NAME OF FATHER John Nagy

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Hungary

14 Informant Helen Nagy (Address) 4606 Glenarm Ave.

15 Filed ..., 19 ... Registrar

C. Hampson Jones, M.D.

1 9 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to Dec 18, 1929, that I last saw h... live on Dec 18, 1929, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Heart Disease

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Patrick, M. D.

12/19/1929 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec 21, 1929
20 UNDERTAKER	ADDRESS
Frederick Lasadny	Frederick

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52131 HEALTH DEPARTMENT—CITY OF BALTIMORE 24-801 E. 52131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital 24 REGISTERED NO. 11-25

CITY OF BALTIMORE: (No. 1000 Eaton Ave ST.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Conway

(a) RESIDENCE No. 616 Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Gethus Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jenkins Memorial Hospital

(Address) 1000 Eaton Ave

15 FILED DEC 19 1929 C. HAMPSON JONES, M. D. Registrar

No. 2868

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Dec. 18, 1929, that I last saw her alive on Dec. 17, 1929, and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clarence Bremer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 12/20 1929

20 UNDERTAKER Henry U. Meakes and Son ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Blks.

E 52132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-01 E 52132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 Eager Place ST. 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alduina Pulignani

(a) RESIDENCE No. 2538 Eager Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W-

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ducio Pulignani

6 DATE OF BIRTH (month, day, and year) 12/29/1891

7 AGE: Years 38 | Months 11 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Alexander Uccia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Ducio Pulignani

(Address) 2538 Eager Place

15 C. HARRISON JONES, M. D. 2nd

19 Registrar.

19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-17 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-28, 1929, to 12-17, 1929

that I last saw her alive on 12-17, 1929

and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) unresolved Lobar Pneumonia (duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) S. A. Isaacs M. D.

12-17, 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 12 20 1929

20 UNDERTAKER: George J Ruth

ADDRESS: 1735 Harford Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(McCandlish)

E 52133

HEALTH DEPARTMENT—CITY OF BALTIMORE

93-4 Forrest

CERTIFICATE OF DEATH

1 6 2

E 52133

1-PLACE OF DEATH

City of Baltimore: (No. [redacted] St., 11-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David McCandlish

(a) RESIDENCE NO. [redacted] 93-4 Forrest St

(Usual place of abode) St., [illegible] Ward

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Date received 19 1929 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 19. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Riley

Dec 19, 1929 (Address) 1659 Bway, M. D.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Arlington Am Work D. C.

DATE OF BURIAL 12/20 1929

20 UNDERTAKER Robert Brooks

ADDRESS Calhoun Hastings

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52134

CERTIFICATE OF DEATH.

18 Vol. 506 Line 4275

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General St. Hosp. Ward 5 600)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Wiedey

(a) RESIDENCE NO. 2816 Clifton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Wiedey

6 DATE OF BIRTH (month, day, and year) Dec 2, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mallory Company

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Wiedey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Kate Mahle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mrs Emma A. Wiedey

(Address) 2816 Clifton Ave

15 Filed Dec 19 1929 C. HAMPSON JONES, M. D. Registrar

Per NRH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cellulitis of Finger

Injured in Automobile Shop

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Septicemia

(Duration) yrs. mos. 3 ds.

Signed (Coroner) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Dec 21 1929

20 UNDERTAKER ADDRESS

Wm Cook 1217 N. Paul St

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52135

CERTIFICATE OF DEATH

15-1 ✓ E 52135

1—PLACE OF DEATH

REGISTERED NO. 15-66

CITY OF BALTIMORE: (No. 1809 Whitmore Av ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George N. Gaspiel

(a) RESIDENCE NO. 1809 Whitmore Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eva M. Gaspiel

6 DATE OF BIRTH (month, day, and year) Apr. 16th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. J. Gaspiel

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Lewis

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs Eva Gaspiel

(Address) 1809 Whitmore Av.

15 Filed 1 9 1928 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19/29

17 I HEREBY CERTIFY, That I attended deceased from Dec., 1927, to Dec 19th 1929, that I last saw him alive on Dec. 18th 1929 and that death occurred, on the date stated above, at 820 A m.

The CAUSE OF DEATH* was as follows:

Gangrene of toe, both feet
Endarteritis Obliterans

(duration) yrs. 22 mos. ds.

CONTRIBUTORY (Secondary) Congestion of lungs & pharynx Hemorrhoids

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) [illegible], M. D.

12/19, 1929 (Address) 1605 N. York Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec 21st 1929
UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52136

CERTIFICATE OF DEATH

92 E 52136

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3000 St. Paul St. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael E. McColgan

(a) RESIDENCE NO. 3000 St. Paul St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles McColgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles C. McColgan

(Address) 3000 St. Paul St.

15 Filed 1 9 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1927, to Dec 18, 1929, that I last saw h[illegible] alive on Dec 18, 1929 and that death occurred, on the date stated above, at 10, m.

The CAUSE OF DEATH* was as follows:

Renal arteriosclerosis.
Hypostatic pneumonia

(duration) Years yrs. mos. ds.

CONTRIBUTORY (Secondary) Preliminary Oedema
Coronary thrombosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Examination

(Signed) J. F. Illman, M. D.

12/19 1929 (Address) 80 E Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Dec. 20/29 19
20 UNDERTAKER	ADDRESS
Bowman & Son	805 N. Calvert St.

Spec.—1-10-21—M&T—1500 Bks.

E 52137 HEALTH DEPARTMENT—CITY OF BALTIMORE 52137

CERTIFICATE OF DEATH.

REGISTERED NO. 1529

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1823 Wilhelm (St.) 19-28 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Mary Wright

(a) RESIDENCE NO. 1823 Wilhelm ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19, 1929

7 AGE — Years: 3 hours + 10 minutes; Months: ; Days: ; If LESS than 1 day, 3 hrs. + 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Thelma Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas Wright (Address) 1823 Wilhelm St

15 Filed 1 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 19, 1929, that I last saw her alive on Dec 19, 1929, and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) 3 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. O'Neill M. D.

12/19, 1929 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem — DATE OF BURIAL: Dec 20, 1929

20 UNDERTAKER: Joseph D Cook — ADDRESS: 1003 W Balto St

TION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Blks.

E 52138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52138

REGISTERED NO. 91002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6115 Stanton St. 13-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Mc Namara

(a) RESIDENCE NO. 6115 Stanton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mc Namara

6 DATE OF BIRTH (month, day, and year) — — 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Quirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Mc Namara

(Address) 6115 Stanton Ave

15 Filed 1 9 1929 C. HANSON JONES, M. D. Registrar

Pol

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 17, 1929, that I last saw h er alive on Dec 16, 1929 and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Arterio sclerotic cardiac disease.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Wm Schmidt, M. D.

Dec 18, 1929 (Address) 842 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Loans	12/20/29
20 UNDERTAKER John F. Gahagan & Sons	ADDRESS 1314 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52139

CERTIFICATE OF DEATH

90

E 52139

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 154 2 Hanover ST. 23-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah E Bahnline

(a) RESIDENCE NO. 154 2 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Bahnline

6 DATE OF BIRTH (month, day, and year) — — 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Edw Seward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Drucella Wad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs A Rebecca

(Address) 154 2 Hanover

15 Filed 1 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to Dec 17, 1929

that I last saw h alive on Dec 17, 1929

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

1a Mitral Regurgitation

1b Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis additional

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Dr. R. E. Campbell M. D.

Dec 19, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Dec 20 1929

20 UNDERTAKER J. F. Bailey Sons

ADDRESS 1318 Light St.

Spec.—1-10-21—M&T—1500 Bks.

E 52140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 E 52140

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eden ST. 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Vogel

(a) RESIDENCE No. 512 So. Curley ST., 1 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mayt. Vogel.

6 DATE OF BIRTH (month, day, and year) Dec. 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
62	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edmir Vogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis E. Vogel.

(Address) 512 S. Curley St.

15 Filed ... C. H... JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-4-, 1929, to 12-17, 1929, that I last saw him alive on 12-17, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Hypostatic Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Prostate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) M. McGuckin, M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Dec 20th 1929

UNDERTAKER Lilly & Feiler Inc. — ADDRESS 403 S. Wolfe St

DEC 20 1929

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52141

CERTIFICATE OF DEATH.

126 E 52141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 W Saratoga St., 18-16 WARD)

2-FULL NAME Edward West

(a) RESIDENCE No. 1034 W Saratoga ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Alverta Fruby West

6 DATE OF BIRTH (month, day, and year): April 3 1894

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
35	8	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer): Self 641
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS
10 NAME OF FATHER: Tony West
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Maria Thomas
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Alverta Fruby West
(Address) 1034 W Saratoga St

15 Filed DEC 20 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 1929 to Dec 19 1929 that I last saw him alive on Dec 18 1929 and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
(Cause unknown)
(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Hawkins M. D.
(Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Dec. 22, 1929

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 N Schroeder St

FOR IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 90 ✓

E 52142

REGISTERED NO.

15-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2922 W. North Avenue ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmira Virginia Mowen

(a) RESIDENCE NO. 2922 W. North Avenue ST., WARD Pitman, N. J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 10 ds. How long in U. S., if foreign birth 85 yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel H. Mowen

6 DATE OF BIRTH (month, day, and year) December-28-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	85	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) New York City
(State or country) New York

PARENTS

10 NAME OF FATHER Richard B. Freeman

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) England

12 MAIDEN NAME OF MOTHER Elizabert C. Magan

13 BIRTHPLACE OF MOTHER (city or town) Long Island
(State or country) New York

14 Informant Mrs. Blanche Howarth (niece)
(Address) 2922 W. North Avenue

15 Filed ....., 19.... C. HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18/29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1929, to Dec. 18, 1929, that I last saw h.. alive on Dec. 18, 1929 and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) chronic myocarditis

(duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Abelman M. D.

12/19, 1929 (Address) 3300 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Dover, Deleware

DATE OF BURIAL
Dec-23-29 19

20 UNDERTAKER
STEWART & MOWEN COMPANY
WILLIAM S. MOWEN, Proprietor

ADDRESS
108 W. NORTH AVE.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52143

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 52143

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospls REGISTERED NO.

CITY OF BALTIMORE. (No.) Balto Md. ST., 27-53 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H.B. Parker

(a) RESIDENCE NO. 4606 Wilmslow Road. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma F. Parker

6 DATE OF BIRTH (month, day, and year) 8/21 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Machinist 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Akehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records (Address) Balto City Hospls

15 Filed [illegible] 19 Registrar

C 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19-29

17 I HEREBY CERTIFY, That I attended deceased from 12-4-, 1929 to 12-19, 1929 that I last saw him alive on 12-19, 1929 and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Psychosis = Hypertension + Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) John H. Edmunds M. D.

12/19, 1929 (Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec 21 1929.
20 UNDERTAKER Stewart & Co	ADDRESS Balto

Spec.—2-29-28—L. F. S.—500 Blks.

E 52144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52144

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2109 St. Paul ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Therese Wedekind

(a) RESIDENCE NO. 2109 St. Paul ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 45 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Gustav A. Wedekind

6 DATE OF BIRTH (month, day, and year) Sept-6-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
✓	81	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of indostry, business, or establiishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Altona

(State or country) Germany

PARENTS

10 NAME OF FATHER Chas. Hageman

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Weber

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country) Germany

14 Informant Mrs Ella M. Wedekind (daughter)

(Address) 2109 St Paul St City

15 Filed DEC 20 1929 C. HERMON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 29

17

I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to Dec 18, 1929

that I last saw her alive on Dec 18, 1929

and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Acute dilatation Heart with pulmonary oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H H Pearce, M. D.

12-18-1929 (Address) 2105 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec 20 1929.

20 UNDERTAKER Stewart Memorial Co ADDRESS Balto.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1291 E 52145

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3815 Juniper Road St. Guilford WARD)

2—FULL NAME Susan Emma Placide

(a) RESIDENCE NO 3815 Juniper Road St. Guilford WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 11th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	81	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry S Placide

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Susan Hillmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Henry P. Willmer

(Address) 3815 Juniper Rd Guilford

15 Filed DEC 10 1929 19 ELMER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 19, 1929, that I last saw her alive on Dec 19, 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease ?
Uraemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Blood Exam.

(Signed) Jos A Luntz Jr M. D.

Dec 19 1929 (Address) 1 E Read St - Ballard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec 21 1929
20 UNDERTAKER	ADDRESS
Henry Jenkins & Son Co.	Eutaw & Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

E 52146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

108-001.

E 52146

1—PLACE OF DEATH Baltimore Md

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Royal Apts ST. Mt Royal & Calvert WARD 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ada O'Donnell Hoolton

(a) RESIDENCE NO. Mt Royal Apts ST. Mt Royal & Calvert ST., 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry E. Hoolton

6 DATE OF BIRTH (month, day, and year) Feby 7 - 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John O'Donnell

11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Palmer

13 BIRTHPLACE OF MOTHER (city or town) Newyork (State or country) Newyork

14 Informant Mrs C. M. Sills (Address) Norfolk Va

15 Filed DEC 20 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to Dec 19th, 1929

that I last saw her alive on December 19, 1929

and that death occurred, on the date stated above, at 2.42 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Cary Paran, M. D.

Dec 19th 1929 (Address) Mt Royal Hotel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holmes Elkcott City	Dec. 21 1929
20 UNDERTAKER Henry Hinkins & Co	ADDRESS Catonsville Md.

Spec.—1-10-21—M&T—1500 Bks.

Romison

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52147

CERTIFICATE OF DEATH.

148 ✓ 52147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hosp.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 15-21 WARD)

2-FULL NAME Mrs. Pearl Rimson

(a) RESIDENCE No. 1728 N. Monroe St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Rimson

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wolf Radigofsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Devorah Hurwitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Morris Rimson

(Address) 1728 N. Monroe St

15 DEC 20 1929 Filed H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1929, to Dec. 19, 1929, that I last saw her alive on Dec. 19, 1929, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Parenchymatous

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) M. B. Schneider, M. D.

Dec 19 1929 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Henry Run — DATE OF BURIAL Dec 20 1929

20 UNDERTAKER A Feuman Bro — ADDRESS 1127 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52148

CERTIFICATE OF DEATH

101-001 E 52148

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 9-47

CITY OF BALTIMORE: (No. Calvert & 33rd St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Robert Schroeder (Margaret L.

(a) RESIDENCE NO. 604 Melville Ave ST., Balto. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4/ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Schroeder

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph W. Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mamie Gillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robert L. Schroeder

(Address) 604 Melville Ave

15 DEC 20 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 4th 14, 1929, to Dec 19, 1929,

that I last saw her alive on Dec 14, 1929

and that death occurred, on the date stated above, at 7.00 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home (604 Melville Ave)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart & Respiration ceased.

(Signed) Francis W. Schluck, M. D.

Dec 19, 1929 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec. 23rd 1929

20 UNDERTAKER Henry Koch & Sons, Inc.

ADDRESS 1301 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52149

CERTIFICATE OF DEATH

179 ✓ E 52149

1-PLACE OF DEATH

City of Baltimore: (No. Pagordent Hosp St., 15-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Williams

(a) RESIDENCE NO. 1382 N. Carey St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert.

6 DATE OF BIRTH (month, day, and year): Nov - 1903

7 AGE: Years 26 | Months 1 | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): 07°
(c) Name of employer

9 BIRTHPLACE (city or town): N. C.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: Anne Foster

13 BIRTHPLACE OF MOTHER (city or town): N. C.
(State or country)

14 Informant: Olevia Foster
(Address): 561 Leslie st

15 Filed Dec 20 1929 19 J. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd degree burns
Accidentally burned by flame

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. E. Gelbach M. D.

Dec 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Dec 20 19 29

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pressman

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Wright

E 52150

CERTIFICATE OF DEATH

129 E 52150

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 930 S. Bouldin ST. 16-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Valentine Gerlach

(a) RESIDENCE NO. 930 S. Bouldin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Gerlach

6 DATE OF BIRTH (month, day, and year) March 14-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	84	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) none 013

(c) Name of employer none

9 BIRTHPLACE (city or town) Not known (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Gerlach

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country) Not known

14 Informant Minnie Gerlach

(Address) 930 S. Bouldin St.

15 Filed DEC 20 1928 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18-1929

17 I HEREBY CERTIFY, That I attended deceased from about Jan. 1912, to Dec 15, 1929

that I last saw h[illegible] alive on Dec 17, 1929

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12-20, 1929 (Address) 1114 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Dec 21 1929

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager st

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52151

CERTIFICATE OF DEATH

REGISTERED NO. E 52151

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Piedmont Ave. ST. Sobel WARD)

2—FULL NAME Lillie Schloss

(a) RESIDENCE NO. 3205 Piedmont Ave WARD Baltimore 2nd

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 16, 1869

7 AGE: Years 60 | Months 7 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Seligman Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mina Lazarus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: J. C. Lycett

(Address) 317 N. Charles St

15 Filed [illegible] 1929 HARRY JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Thurs. Dec. 19th 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1929, to December 19th 1929, that I last saw h[illegible] alive on December 19th 1929, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF STOMACH & METASTASES IN LIVER

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Not applicable

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X Ray Findings

(Signed) Thomas Conradi M. D.

Dec. 19, 1929 (Address) 102 E 36th St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	12/20/1929
20 UNDERTAKER: David Lowenheim	ADDRESS 112 20 W. Mt Royal

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52152

CERTIFICATE OF DEATH

89 E 52152

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1207 Eutaw Place. St. 27-56 Ward)

2-FULL NAME Samuel Fronsdorf

(a) RESIDENCE NO. Arlington Park Apts. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Etta Arnstein Fronsdorf

6 DATE OF BIRTH (month, day, and year) April 3rd. 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	62	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work President Federal
(b) General nature of industry, business, or establishment in which employed (or employer) Yeast Corp.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Michigan.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Clarence Cohn
(Address) Arlington Park Apts.

15 Filed DEC 20 1929, 19.. C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Polk Coroner, M. D.

Dec 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cheb Shalom Cem. DATE OF BURIAL: 12/20/ 1929

20 UNDERTAKER Harry Sondheim ADDRESS 118 20 W. Mt. Royal Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Write DEATH in plain terms, so that it may be properly classified.

*Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 52153

CERTIFICATE OF DEATH.

90 ✓ B 52153

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1124 E Fayette St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Siegel

(a) RESIDENCE NO. 1124 E. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	077	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Sidney Siegel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Bessie Siegel

(Address) 1124 E Fayette St

15 Filed DEC 1929 H. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Renal Sclerosis

years (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

Dec 20 (Signed) W. J. Kelly Carlson M. D.

, 19 29 (Coroner) (Address) 1639 Bremerton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run Date of Burial Dec 20 1929

20 UNDERTAKER S Lemson Bro ADDRESS 1117 E Baltimore St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52154

CERTIFICATE OF DEATH

33 ✓ E 52154

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital St. 10-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Fritz

(a) RESIDENCE NO. 519 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Fritz. (Ida M.)

6 DATE OF BIRTH (month, day, and year) SEPT. 27, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	49	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Switchboard worker

(b) General nature of industry, business, or establishment in which employed (or employer) Electricia[illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Baltimore~~ Tyrone –

(State or country) – Md.

PARENTS

10 NAME OF FATHER Mordecai Fritz.

11 BIRTHPLACE OF FATHER (City or town) ~~Baltimore~~

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Botzum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ~~Germany~~ Germany.

14 Informant Hospital Records

(Address)

15 Filed 20 1929, 19 C. HERBERT JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/17 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/10, 1929, to 12/17, 1929, that I last saw h~~im~~ alive on 12/17, 1929, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Tbc. peritonitis & B. coli infection

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Surgical shock & cardiac failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 12/11/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

I ~~Signed~~ [illegible] M. D.

(Address)

12/17/29

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Lorraine Cemetery	Dec. 20-1929.
20 UNDERTAKER	ADDRESS
Charles J. Schwab.	505 N. Monroe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52155

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-091

E 52155

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Ruley

(a) RESIDENCE NO. 515 N. Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) God

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER George P. Ruley

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Stern

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Mrs. Elizabeth Ruley
(Address) 515 N. Glover

15 FILED ..... 19 ..... H. MCKIM JONES, M. D.
Registrar

E 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19-29

17 I HEREBY CERTIFY, That I attended deceased from December 14, 1929, to December 19, 1929, that I last saw h[e] alive on December 19, 1929 and that death occurred, on the date stated above, at 1[15] [illegible] m.

The CAUSE OF DEATH* was as follows:

Bilateral Broncho Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Bilateral Suppurative Otitis Media

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Incision Date of 12/16/29

Was there an autopsy? No Yes drums

What test confirmed diagnosis?

(Signed) David Penner, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 21 1929
20 UNDERTAKER	ADDRESS
Jos. J. Stein	156 N. Luzerne

Spec.—2-20-28—L. F. S.—500 Bks.

E 52156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 √E 52156

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 E Fayette ST. 6-10 WARD)

2—FULL NAME Patrick Mullin

(a) RESIDENCE NO. 2516 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie J Mullin

6 DATE OF BIRTH (month, day, and year) April 14 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	√ 63	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) C & P Tel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Mullin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie J Mullin

(Address) 2516 E Fayette St

15 Filed 20 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-17-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to 12-17-29

that I last saw him alive on 12-15-29

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Myocarditis, Hypostatic Pneumonia, Arteriosclerosis

CONTRIBUTORY (Secondary) Acute Dilatation (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12-19-29 (Address) 1501 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL 12-21 1929

20 UNDERTAKER Wm Chas A Rohde — ADDRESS 2327 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52157

CERTIFICATE OF DEATH

+ 148 ✓ E 52157

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Nursery Ave ST. 4 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsie Effert

(a) RESIDENCE NO. Elkridge Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raymond Green

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE: Years 38 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Beltran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Raymond Green
(Address)

15 Filed DEC 20 1929 H. M. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/19/29

17 I HEREBY CERTIFY, That I attended deceased from 12/19/29, 19 29, to 12/19/29, 19 29

that I last saw her alive on 12/19/29, 19

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia Gravidarum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Signs

(Signed) Edward A. Fisher, M. D.

, 1929 (Address) Hammonds Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: 12/22 1929

20 UNDERTAKER: Edward A. Fisher

ADDRESS: Lemmon

Cor.—10-10-29—A Co.—100 Bks.

E 52158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-901 E 52158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 811 Peach Alley. St. 22-31 Ward)

2-FULL NAME Charles Stanley.(C)

(a) RESIDENCE NO. 811 Peach Alley. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced, HUSBAND of Sarah E.Stanley.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver.
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Harrison Stanley.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Sarah E. Stanley.(C) wife.
(Address) 811 Peach Alley.

15 Filed ..., 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) December 17, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Bernhardt, M. D.

12/18 1929 (Address) 1917 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Dec 20 1929

20 UNDERTAKER S. L. Brown's Son

ADDRESS 1018 W. Monty

$7

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 52159

1-PLACE OF DEATH

City of Baltimore: (No. Lotty Hospital St. 18-No Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucindy Bank

(a) RESIDENCE NO. 1006 N. Sarah Ann Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Bank

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Nannie Monroe
(Address) 1006 Sarah Ann St

Filed DEC 20 1929 C. HAMPSON JONES, Jr. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary) Carbuncle (duration) 1 yrs. mos. 7 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

What was the autopsy? —

What was confirmed diagnosis? Autopsy

(Signed) H. G. Slade, M. D.

Dec 19, 29 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Dec 21, 1929

20. UNDERTAKER Mrs. Katie R. Williams — ADDRESS 323 N Schroeder St

IMPORTANT. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52160

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 52160

101-001

16-23

CITY OF BALTIMORE: (No. 1115 N. Carey ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Blackston

(a) RESIDENCE No. 1115 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Blackston

6 DATE OF BIRTH (month, day, and year): Feb 22. 1904

7 AGE

Years	Months	Days	If LESS than 1 day..... hrs. or ...min
25	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis, Md

PARENTS

10 NAME OF FATHER: Bennie Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Modock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma Blackston

(Address): 1115 N. Carey St

15 Filed 2 01929, 19 [illegible] Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 13th, 1929, to Dec 18th, 1929, that I last saw h alive on Dec 18, 1929, and that death occurred, on the date stated above, at 8:15 P m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

12/20 1929 (Address) 1916 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Dec. 21 1929

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Presstman St

Spec.—2-29-28—L. F. S.—500 Bks.

E 32092
E 32161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 84 ✓

E 52161

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME Samuel A. Mudd

(a) RESIDENCE NO. Waldorf - Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Self 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Mudd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Bird

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rural
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19/29

17 I HEREBY CERTIFY, That I attended deceased from December 13, 1929, to December 19, 1929, that I last saw h[illegible] alive on December 19, 1929 and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, cerebello pontile angle, right (Benign)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? yes Date of Dec 13, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence B Gardner Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waldorf Md — DATE OF BURIAL 12/21 1929

20 UNDERTAKER Wm Cook — ADDRESS 1214 St Paul St

JOHNS HOPKINS HOSPITAL
20 1929 H. HINMAN JONES, M.D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52162

CERTIFICATE OF DEATH

91-002E 52162

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. North Bend Rd & Edmondson Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Tunbrook

(a) RESIDENCE NO. North Bend Rd & Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write one word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Alfred D Tunbrook

6 DATE OF BIRTH (month, day, and year): Nov 20 1845

7 AGE: 84 Years | 10 Months | 29 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Hedgistown W Va

PARENTS

10 NAME OF FATHER: John H Early

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: Hannah E Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W Va

14 Informant: Alfred D Tunbrook

(Address) N Bend Rd & Edmondson Ave

15 Filed ... 19 ... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Dec 19, 1929, that I last saw h alive on Dec 19, 1929 and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Paraphymotosis Left Arm

(duration) ... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A. C. Lemmon, M. D.

Dec 30 1929 (Address) 4209 Gibson Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine

DATE OF BURIAL: 12/21 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 2174 Pool St

Spec.—1-50-12-29-15M Blks.

E 52163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 52163

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST. 19-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur V Bushnell

(a) RESIDENCE NO. 197 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Laura Bushnell

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) N. Y

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Laura Bushnell (Address) 197 Calhoun

15 Filed DEC 20 1929 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-18 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-29, 1929, to 12-18, 1929, that I last saw her alive on 12-18, 1929, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 14

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Ehen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 12/21/1929

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52164 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 52164

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Ettel

(a) RESIDENCE NO. 2010 Wadsworth Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chopper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant Hospital Records

(Address)

15

Filed 20 DEC 29 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/29

17

I HEREBY CERTIFY, That I attended deceased from 8/12 19 29 to 12/19 19 29

that I last saw him alive on 12/19 19 29

and that death occurred, on the date stated above, at 5 25 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular Disease

7 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of right toe, left foot

Hospital stay (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/14/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. N. McDaid Jr. M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 24 Dec 1929

20 UNDERTAKER Josiah Syfer

ADDRESS 1600 W. Lexington St.

Cor.—12-9-25—A Co.—200 Bks.

E 52165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 52165

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 754 Pacific St 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa L. Wilson

(a) RESIDENCE NO. 754 Pacific St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Joseph Wilson

6 DATE OF BIRTH (month, day, and year): Feb 27-1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Scotland

10 NAME OF FATHER: John Kennedy

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Gunn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

PARENTS

14 Informant: Mrs Wilson

(Address): 754 Pacific St

15 Filed: Park Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

Uraemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. H. Brook M. D.

(Coroner)

Dec 18 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Laurel Date of Burial Dec 21 1929

20 UNDERTAKER: A S Marshall ADDRESS 3539 Gall Rd

DEC 20 1929

Very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52166

CERTIFICATE OF DEATH.

129 E 52166

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3006 Dennore av St. 27-56 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Buttner
Sarah

(a) Residence No. 3006 Dennore av St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: J. L. Buttner

6-DATE OF BIRTH (month, day and year): Sept 11-1852

7-AGE: 77 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Co.

PARENTS.

10-NAME OF FATHER: Joseph Jackins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): France

12-MAIDEN NAME OF MOTHER: Sarah Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Co

14-
(Informant): W. L. Buttner
(Address): 3006 Dennore Ave

15-
Filed 20 1929 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/19/29

17- I HEREBY CERTIFY, That I attended deceased from Jan 19 26 to Dec 18 19 29

that I last saw h.. alive on Dec 18 19 29

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:
Cardiac Failure
Chr. Myocarditis
& Hypertrophy.

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Chr. Interstit. nephritis

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? none.

What test confirmed diagnosis? Physical Exam.

(Signed) M. Greenbaum M. D.

, 19 (Address) 402 Reedeln

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Dec 21, 19 29

UNDERTAKER: A. D. Marshall

ADDRESS: 3539 Fall Rd

Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 52167

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643 Cliftview Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Wilbur Francis Moberly

(a) RESIDENCE NO. 1643 Cliftview Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Moberly

6 DATE OF BIRTH (month, day, and year) 12/31/1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24 25	11 11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) odd jobs

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md

PARENTS

10 NAME OF FATHER Ernest Moberly

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Anderson

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Md

14 Informant Mrs Alice Moberly

(Address) 1643 Cliftview Ave

15 Filed 2 0 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18/29

17 I HEREBY CERTIFY, That I attended deceased from 8/23/29, 19, to 12/18, 19 29, that I last saw him alive on 12/2/29, 19, and that death occurred, on the date stated above, at 4:10 a m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & clinical signs

(Signed) James Brown M. D.

, 19 (Address) 705 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL 12/21/29

20 UNDERTAKER George J. Puth — ADDRESS 1235 Hoff

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52168

CERTIFICATE OF DEATH.

37

E 52168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1537 Woodyear ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lothie Morris

(a) RESIDENCE NO. 1537 Woodyear ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Forenys Morris

6 DATE OF BIRTH (month, day, and year) Sept 16, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Clarence Darby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hesler Gaskins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Forenys Morris

(Address) 1537 Woodyear

15 DEC 20 1929 C. HAMPSON JONES, M. D. Registrar

Per ACB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 20, 1929, that I last saw h[illegible] alive on Dec 17, 1929, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Willman Frey M. D.

12/20, 1929 (Address) 1708 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: White Stone Va. DATE OF BURIAL: 12/22 1929

20 UNDERTAKER: Robert E. Williams ADDRESS: 1515 McEdem st

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52169

CERTIFICATE OF DEATH

90 E 52169

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 2850 N. Charles ST. 12-5T WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Jane Walls

(a) RESIDENCE NO. 2850 N. Charles ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr. 2, 1836

7 AGE: Years 93 | Months 8 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Nathaniel Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country): a a Co. Md.

12 MAIDEN NAME OF MOTHER: Catherine Blair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Roland Watts. (Address) Entaw & Fayette Sts.

15 Filed Dec 20 1929, 19 G. HARRISON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to Dec. 19, 1929, that I last saw her alive on Dec. 19- 1929 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities of Age

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Wm. M. Bamebaker, M. D.

, 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. | DATE OF BURIAL: Dec 21 1929

20 UNDERTAKER: Wm. J. Tickner & Sons | ADDRESS: North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52170

CERTIFICATE OF DEATH

25-001 V

E 52170

1—PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 46th St. & Cedar Ave. St.) WARD 13-53

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Elizabeth Bennett

(a) RESIDENCE NO. Home for Incurables St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas J. Bennett

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Creamer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Home records

(Address)

15 Filed DEC 20 1929 C. HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 "1929

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1928 to Dec 18, 1929

that I last saw her alive on Dec 18, 1929

and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

Hemiplegia

(duration) — yrs. 18 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Oedema

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) H H B Mayo, M. D.

Dec 19 '29 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Dec 21 1929

20 UNDERTAKER Wm Tuckner & Sons

ADDRESS N. Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 52171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9-1-00 ✓ E 52171

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3604 White Ave ST. 27-43 WARD

2—FULL NAME Annie D. Gray

(a) RESIDENCE NO. 3604 White Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER James A. Gray

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Egerton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George Cook

(Address) 3604 White Ave.

15 Filed 12 01929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18th 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 19 29, to Dec 18, 19 29, that I last saw her alive on Dec 17, 19 29 and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis many years (Senility)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Green, M. D.

12/18 19 29 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 21 19 29

20 UNDERTAKER Hughes & Jones Inc — ADDRESS 424 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 52172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52172

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Indea York.

(a) RESIDENCE No. 1600 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard York.

6 DATE OF BIRTH (month, day, and year) ? ? 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Laura Fairbanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Howard York (Address) 1600 N. Spring St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-13 1929 to 12-19 1929, that I last saw h er alive on 12-19 1929, and that death occurred, on the date stated above, at 10 40 a m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & Thrombosis involving the veins of entire Lt. Leg and Thigh.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/19/29

Was there an autopsy?

What test confirmed diagnosis? Operative findings

(Signed) A. Aub Owens M. D.

, 19 (Address) Wendel Court Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery, Chase Md. DATE OF BURIAL Dec 22 1929

20 UNDERTAKER Hughes & Jones Inc ADDRESS 1424 W Broadway

ATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 52173

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1122 Hollins ST., 18th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George J. Snoops, Sr.

(a) RESIDENCE NO. 1122 Hollins st. ST., 18th WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 2 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ Amelia Snoop (nee HEIN)

6 DATE OF BIRTH (month, day, and year) April 17, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit and Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles J. Snoops

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Klein

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant George J. Snoops, Jr.

(Address) 1122 Hollins st.

15 Filed DEC 20 1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/29

17 I HEREBY CERTIFY, That I attended deceased from 3/14/29, 19..., 12/19/29, 19..., that I last saw him alive on 12/17/29, 19..., and that death occurred, on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Asthenia

..... (duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Cancerous of Pylorus

..... (duration) ... yrs. 10 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 3/20/29

Was there an autopsy? No

What test confirmed diagnosis? Inlaparotomy

(Signed) G. H. Dorsey, M. D.

12/20/29 (Address) 575 Spruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk — DATE OF BURIAL Dec. 21st 1929

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor

Spec.—2-29-28—L. F. S.—500 Blks.

E352974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 52174

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 25-75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Summers

(a) RESIDENCE NO. 1929 Druid Park Ave ST., Normal Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Summers

6 DATE OF BIRTH (month, day, and year) May 7-86

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Car Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Header

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address)

15 Filed DEC 30 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-19-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Dec 19, 1929, that I last saw h.. alive on Dec 19, 1929, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Hypophyseal Adenoma (Benign)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/14/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence E Gardner Jr., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ag Redeemer

DATE OF BURIAL Dec 23 1929

20 UNDERTAKER Frank Coach & Son

ADDRESS 1906 Eastlan Ave

Spec.—2-29-28—L. F. S.—500 Blks.

Hook ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52175

CERTIFICATE OF DEATH

90 E 52175

1—PLACE OF DEATH

(REGISTERED NO.)

CITY OF BALTIMORE: (No. 828 W. Baltimore St. ST. 18-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lilly Goldie Hook

(a) RESIDENCE NO. 828 W. Baltimore St ST., WARD

(Usual place of abode) 18

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip Hook

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	11	18 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S. A.

PARENTS

10 NAME OF FATHER Edward F. Dutcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Van Valkenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill.

14 Informant Mr. Phillip Hook

(Address) 828 W. Baltimore St

15 Filed 2 0 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18-29

17

I HEREBY CERTIFY That I attended deceased from Nov 1, 19 29, to Dec 18, 19 29, that I last saw h. alive on Dec 18, 19 29 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

Dec 20 19 29 (Address) 2687 Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetary	Dec. 21 19 29

20 UNDERTAKER Harry A. Weitzke ADDRESS 4101 Edmondson Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 52176

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md General Hosp (Street) 10-69 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia P. Mary

(a) RESIDENCE NO. 315 S. Smallwood St. (Street) Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Franz L. Mary

6 DATE OF BIRTH (month, day, and year): Sept 1st 1853

7 AGE: Years 76 Months 2 Days 17

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country):

PARENTS

10 NAME OF FATHER: Roenert

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilkinson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Hosp. Records

(Address)

15 Filed 2 0 1929

16 [illegible] JOHNSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 12-18-29

17 I HEREBY CERTIFY, That I attended deceased from 11-9-29, 19..... to 12-18-29, 19.....

that I last saw her alive on 12-18-29, 19.....

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Fracture of Middle third of left femur

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Md Thompson M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westlawn Cemetery Date of Burial 12/21/1929

20 UNDERTAKER: J. B. Plunkett ADDRESS 1850 W Baltimore St

very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52177

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 828 N. Fulton Ave. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia R. McFee

(a) RESIDENCE NO. 828 N. Fulton Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. McFee

6 DATE OF BIRTH (month, day, and year) Aug. 28, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Oxford
(State or country) Maryland

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not obtainable

12 MAIDEN NAME OF MOTHER Louisa Bowdell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not obtainable

14 Informant James McFee
(Address) 828 N. Fulton Avenue

15 Filed 2 0 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Dec 19, 1929, that I last saw her alive on Dec 14th, 1929, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Chr. Nephritis - Arteriosclerosis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Chem

(Signed) L. M. C. Carter, M. D.

12/20, 1929 (Address) 1114 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/21 19 29

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

E 52178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 52178

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4 25 Ward)

2-FULL NAME William Maynard

(a) RESIDENCE NO. 639 Vine St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Maynard
(Address) 624 McCulloh St

15 Filed 0 1929 Registrar

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17- 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia due to general 2nd. & 3rd. degree burns of face - upper extremities & body.

Homicide (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 639 Vine St

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edgar Tillers, M. D.

12-10. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount N. C.

DATE OF BURIAL 12/20/29

20 UNDERTAKER Samuel H. Wensley

ADDRESS 5[illegible] Biddle

Please print in ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 52179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 52179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3119 Rumley St. WARD) 25-76

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie H. Mason

(a) RESIDENCE. NO. 3119 Rumley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Sloan Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Benjamin Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Annie Mason
(Address) 3119 Rumley St

15 Filed 2 0 1929 19 C. HAMPSON JONES, M. D. Registrar

By ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 29

17

I HEREBY CERTIFY, That I attended deceased from Dec-12 19 29, to Dec-19 19 29, that I last saw h alive on Dec-19 19 29, and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows

Bronchial pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Coleman, M. D.

Dec 21 19 29 (Address) 203 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	Dec 21 19 29

20 UNDERTAKER Robert W. Wilson ADDRESS 1515 McCulloh St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 52180

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 020 N. Bethel St., 7-9 Ward)

2-FULL NAME Charles Mayo

(a) RESIDENCE NO. 020 N. Bethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15/29

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Harris Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Mayo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Virginia Mayo
(Address) 020 N. Bethel St

15 Filed 2-20 1929 C. HARRISON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos H Green, M. D.

2/20/1929 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	Dec 24 1929
20 UNDERTAKER	**ADDRESS**
Robert Williams	1615 McCulloh St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52181

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

117 E 52181

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 6-9 Ward)

2-FULL NAME Olivia Thompson

(a) RESIDENCE NO. 230 N. Durham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8/1919

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	10	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Child
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Walter Thompson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Rosa Thompson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Rosa (Johnson) Thompson
(Address) 230 N. Durham St

15 Filed ....., 19.... C. HARRISON JONES Registrar

2 01929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 20/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/20/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westmoreland Co Va	Dec 22 1929
20 UNDERTAKER	ADDRESS
Robert E Wellham	1515 McCulloh St

IF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26--A Co.--300 Bks.

E 52182

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52182

CERTIFICATE OF DEATH

47

1-PLACE OF DEATH Ellen S. Green

REGISTERED NO.

City of BALTIMORE: (No. 1715 Clarkson St. Ward 23-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen S. Green.

(a) RESIDENCE NO. 1715 Clarkson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 25 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josiah F. Green.

6 DATE OF BIRTH (month, day, and year) May. 24, 1859.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	70.	6.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Zachus De.Bou.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dont Know.

14 Informant Josiah F. Green.

(Address) 1715 Clarkson St.

15 Filed DEC 20 1929 C. MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19. 19 29.

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 29 to Dec 19 19 29

that I last saw her alive on Dec 17 19 29

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows: Cardiac asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duodenal ulcer 15

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Bone M.D.

12/20. 19 29 (Address) 6 Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem Date of Burial Dec 21, 1929

20 UNDERTAKER A. Edward Evans & Son ADDRESS

If DEATH in plain rooms, so that it may be the property claimed. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52183

CERTIFICATE OF DEATH

× 90 E 52183

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbur Reedy

(a) RESIDENCE NO. Ellicott City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Reedy

6 DATE OF BIRTH (month, day, and year) May 22, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Abraham Reedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Holler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Records

(Address) University Hospital

15 DEC 20 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Dec 20, 1929, that I last saw h/M alive on Dec 20, 1929 and that death occurred, on the date stated above, at 12:40 P m.

The CAUSE OF DEATH* was as follows:

Heart disease, Arteriosclerotic, Myocardial Degeneration

Myocardial Insufficiency, congestive

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes— What test confirmed diagnosis? Clinical & Laboratory generally Arteriosclerosis, Bronchopneumonia

(Signed) W. B. Draper, M. D.

12/20, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Dec. 23, 1929
20 UNDERTAKER	ADDRESS
Easton Bros	Ellicott City

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52184

CERTIFICATE OF DEATH.

90 E 52184

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 N. Robinson St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian M. Freburger

(a) RESIDENCE NO. 515 N. Robinson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Joseph L.

6 DATE OF BIRTH (month, day, and year) July 7th - 1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Indnstry, business, or establishment in which employed (or employer) 0

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Leonard Lentz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER McCabe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Joseph L. Freburger

(Address) 515 N. Robinson

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 20 / 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to December 20, 1929, that I last saw h[illegible] alive on Dec. 20, 1929, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

(duration) 2 yrs. [illegible] ds.

CONTRIBUTORY (Secondary) Acute Myo[illegible]

(duration) yrs. mos. 2 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jh. Curtis Grimm, M. D.

, 19 (Address) 2951 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Dec. 23 1929

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light St.

very important. See instructions on back of certificates. Full statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52185

CERTIFICATE OF DEATH.

90 E 52185

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2221 Essex St. St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Pruchniewski

(a) RESIDENCE NO. 811 S. Decker Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frank Pruchniewski

(Address) 811 S. Decker Ave

Dec 20 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Stenosis

1 (Duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. E. Lauston M. D.

Dec 19 1929 (Coroner)

,19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial Dec. 21 1929

20 UNDERTAKER John M. Miller & W. H. Chester ADDRESS 220

NRN

Be sure that every question is answered, as the certificate may be properly returned. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52186

CERTIFICATE OF DEATH.

129

E 52186

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 E. Chase St. 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza E. Nicolai.

(a) RESIDENCE NO. 1412 E. Chase St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 21st 1847

7 AGE: Years 82 | Months 10 | Days 26 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 068

(b) General nature of industry, business, or establishment in which employed (or employer) School Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. D. Nicolai

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliza Saunders

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant (Address) Miss J. Mahon 1412 E. Chase.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

16 Buried ..... 19 .....

Undertaker ADDRESS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 - 1929

17

I HEREBY CERTIFY, That I attended deceased from July 4 - 1929, to Dec. 19 - 1929, that I last saw h[illegible] alive on Dec. 19 - 1929, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

12/20/1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Dec 21 1929

Undertaker L. P. Tuselbaugh ADDRESS 2620 St Paul.

DEC 20 1929

Reg. No. 1878

Very important. See instructions on back of certificates.

OCCUPATION IS

E 52137

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 312 E?North Ave. (WARD) 12-19

REGISTERED No. C 7401

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Vogt

(Residence in Baltimore: No. 312 E.North Ave.

Life (If LESS than 1 day, yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	MARRIED

6-DATE OF BIRTH, Sept. 29. 1867, 1
(Month) (Day) (Year)

7-AGE, 62 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Ambrose J.Vogt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Josephine Tabeling

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Thuman

(Address) 3700 Winterborn Road

15- C. HAMPSON JONES, M. D.

DEC 20 1929 191... By ... Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19.1929, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry) thereon and from the evidence obtained by said inquest (autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed (Coroner.) M. D.

12/20, 1929 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem. | DATE OF BURIAL, Dec. 21, 1929

20-UNDERTAKER JOHN O.MITCHELL & SONS | ADDRESS 1900 Eutaw Pla

John O Mitchell Son

Spec.—2-29-28—L. F. S.—500 Bks.

E 52188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 ✓ E 52188

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital-76 ST.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Lee Rogers

(a) RESIDENCE NO. 203 Myrtle Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 1 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Maggie Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Maggie Rogers
(Address) 203 Myrtle Ave

15 Filed DEC 21 1928, 19.. C. HUMSON JONES .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Dec 20, 1929, that I last saw him alive on Dec 20, 1929 and that death occurred, on the date stated above, at 2 25 p.m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1 mos. 28 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 203 Myrtle Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft M.D., M. D.

Dec 20 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Auburn Cem	12-20 1929
20 UNDERTAKER	ADDRESS
Daniel Easton	Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 52139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52189

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 E. Biddle ST. 8-13 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary T. Dreus

(a) RESIDENCE NO. 2028 E. Biddle ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Dreus

6 DATE OF BIRTH (month, day, and year) July 5th 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Peter Kammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Wolf

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Margaret Perry

(Address) 2028 E Biddle St

15 Filed 2 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 29, to Dec 20, 19 29
that I last saw h alive on Dec 19, 19 29
and that death occurred, on the date stated above, at 4 30 P.M.
The CAUSE OF DEATH was as follows: Acute Dilatation of Heart
(Primary)

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] M.D.

12-20-29 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 12/23/1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52190

14-001 ✓ E 52190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 029 Ensor St. 5-8 Ward)

2-FULL NAME Mary Mancuso

(a) RESIDENCE NO. 029 Ensor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Giaviano Mancuso

6 DATE OF BIRTH (month, day, and year) Oct 1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	79	2	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER
"

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Vincent Mancuso (son)
(Address) 1251 E. Lanvale St

15 Filed ...; 19...
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-Peritonitis
Accidently fell over stove in home injuring abdomen following cerebral apoplexy (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(ducation) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. Culotta

(Signed) John Culotta M. D.

12/20/29 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 12-22 19

20 UNDERTAKER H. Cook 1220 St Paul — ADDRESS

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Flossie Gilmore

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52191

CERTIFICATE OF DEATH

101-081 E 52191

1-PLACE OF DEATH

City of Baltimore: (No.) 1327 Myrtan St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Flossie Gilmore

(a) RESIDENCE NO. 1327 Myrtan St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col'd	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Gilmore

11 BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Mack

13 BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

14 Informant Mabel Gilmore
(Address) 1327 Myrtan

Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.

Dec 20 19 29 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Dec. 21 19 29

20 UNDERTAKER Mrs. Kate R. Williams — ADDRESS 3224 Schroeder St.

Oct 21 1929 ANSON JONES Registrar

ARK

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 vE 52192

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 15-24 Ward)

2-FULL NAME Helen Watkins

(a) RESIDENCE NO. 1438 W Pressman St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmal	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Dec 26-1923

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	5	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Silas Watkins

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Franklin

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Silas Franklin
(Address) 1438 W. Pressman

Dec 29 1929 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 29th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry)
find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accident
2nd Degree burn
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Playing with fire.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. E. Faircloth, M. D.
Dec 29 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 12/21 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1307 Pressman St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-00 E 52193

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Warner ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Gross

(a) RESIDENCE NO. 1120 Warner ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Gross

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Co.

(c) Name of employer Northern Coal Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dora Leozer

(Address) 1120 Warner St.

15 Filed 2 1 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20/29

17 I HEREBY CERTIFY, That I attended deceased from 12/7/29, 19.29, to 12/20/29, 19.29, that I last saw h— alive on 12/19/29, 19.29, and that death occurred, on the date stated above, at 2:00 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Cancer

Anemia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis (Influenza)

Lobar Pneumonia (duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. Bradley, M. D.

12/20/29 19 (Address) 1708 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — DATE OF BURIAL Dec 23 19 29

20 UNDERTAKER S. L. Brown & Son — ADDRESS 1054 W. Baltimore

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52194 49 E 52194

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST., 15 WARD

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Edward H R Crum.

(a) RESIDENCE No. 2117 Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 29 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	67 68	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor of Medicine

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Crum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Dunsburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Archie A Thomas

(Address) 15 N. Virginia Ave Brunswick

15 Filed 2 1929 C. HAMPSON JONES, M. D., Registrar. Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1929, to Dec 20 1929.

that I last saw h alive on Dec 20, 1929.

and that death occurred, on the date stated above, at 2-10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic glomerulo-nephritis

Diabetes Mellitus

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Chemical laboratory

(Signed) J. F. Cartagena, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brunswick Md	Dec 21 19

20 UNDERTAKER George J Smith ADDRESS 153 Hollins

FROM A VERY IMPORTANT—SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—6-9-19—H. P. Co.—1000 Bks.

Soden

E 52195 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52195

CERTIFICATE OF DEATH. 24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 Baker ST. 14-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos H Soden

(a) RESIDENCE. NO. 516 Baker ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? 58 yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Soden

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Isaac Soden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Patricia Kinsdyke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robert Soden (Address) 516 Baker St

15 Filed DEC 21 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1929 to Dec 18 1929, that I last saw h alive on Dec 18 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia Contributory Senility

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

(duration) yrs. mos. 7 ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms.

(Signed) Charles W. Thomas M. D.

(Address) 7125 Branch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL 12/21 1929

20 UNDERTAKER Samuel Beecroft ADDRESS 578 N Bridle

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52196 — 124 — E 52196

CERTIFICATE OF DEATH.

1-PLACE OF ~~DEATH~~ CITY OF BALTIMORE: (No.) West Balt Gen'l Hosp. (St.) Ward) — REGISTERED NO. 7645

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Vera Ekman (Ekmann)

(a) RESIDENCE NO. 701 (Usual place of abode) St. Pontiac Brooklyn (Ward) (Nova Scotia) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Ekman

6 DATE OF BIRTH (month, day, and year): Sept 11 1897

7 AGE: Years 32 — Months 3 — Days 8 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Nova Scotia

PARENTS

10 NAME OF FATHER: Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nova Scotia

12 MAIDEN NAME OF MOTHER: Annie Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Nova Scotia

14 Informant: Carl Ekman (Address) 701 Pontiac Brooklyn md

15 Filed 2 1 1929, 19.. C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-19-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1929 to Dec 19 1929, that I last saw her alive on Dec 19 1929 and that death occurred, on the date stated above, at 8-30 P.M.

The CAUSE OF DEATH* was as follows:

(Cardiac dilatation (post operation)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Chr. Obstetrics

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 12-17-29

Was there an autopsy? No. What test confirmed diagnosis? Clinical.

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedarhill Cem — DATE OF BURIAL: 12/20 1929

20 UNDERTAKER: Robert Brooks — ADDRESS: Baltimore Holbrook

FROM is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 52197

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Allendale Road ST. 16-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick Moylan

(a) RESIDENCE NO. 616 Allendale Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Moylan

6 DATE OF BIRTH (month, day, and year) May 27, 1854.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Policeman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Moylan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Timothy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary V. Moylan

(Address) 616 Allendale Road

15 Filed 2 T 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th, 1929.

17 I HEREBY CERTIFY, That I attended deceased from October 1st, 1929, to December 19, 1929, that I last saw h[illegible] alive on December 19, 1929, and that death occurred, on the date stated above, at 7.05 P.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis & interstitial nephritis (duration) over 2 months. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Henry C. Ohle M. D.

12-20, 1929 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec 23, 1929.

20 UNDERTAKER: John J. Cowan & Son. — ADDRESS: 901 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

G.52198 HEALTH DEPARTMENT—CITY OF BALTIMORE G.52198

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE (No. 721 N. Appleton ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Virginia Craft.

(a) RESIDENCE NO. 721 N. Appleton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 3 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph R. Craft.

6 DATE OF BIRTH (month, day, and year) Sept. 16 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	73	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John W. Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Desdemona Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Joseph R. Craft Sr.

(Address) 721 N. Appleton St.

15 Filed ..., 19... Registrar

2 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 14th, 1929, to Dec 19, 1929

that I last saw h[illegible] alive on Dec 19, 1929

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Grover Hemmeter, M. D.

12-20, 1929 (Address) 802 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec 21 1929
20 UNDERTAKER Wm. J. Tickner & Sons	ADDRESS North & Pa

Spec.—1-10-21—M&T—1500 Bks.

E 52199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 082 E 52199

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St Agnes Hospital WARD) 5-7

REGISTERED NO. 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Buckley

(a) RESIDENCE NO. 923 De Soto Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward W Buckley

6 DATE OF BIRTH (month, day, and year): Unknown. 1891

7 AGE: 38 (Years) (Months) (Days) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Sheldon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Ida Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md.

14 Informant: Mr Edward W. Buckley

(Address) 923 De Soto Rd

15 Filed 2 1 1929 . 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-20 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-20 . 1929 to 12-20 . 1929

that I last saw h alive on 12-12-29 . 19

and that death occurred, on the date stated above, at 4.05 p m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brems M. D.

. 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem DATE OF BURIAL: Dec 24 1929

20 UNDERTAKER: John J Cowan & Son ADDRESS: 901 Hollins St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52200

CERTIFICATE OF DEATH

E 52200

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1148 Patapsco Ave. Brooklyn St., 25-75 Ward

2-FULL NAME Margaret J. Krause.

(a) RESIDENCE NO. 1134 Patapsco Ave. Brooklyn. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of Charles L. Krause.

6 DATE OF BIRTH (month, day, and year) March 18, 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Isaac E. Stewart.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Annapolis, Md.

12 MAIDEN NAME OF MOTHER Margaret T. Sheppard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Charles L. Krause. (husband)
(Address) 1134 Patapsco St. Brooklyn.

15 Filed ....., 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Bernhardt, M. D.

12/19/29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec 23 19 29
20 UNDERTAKER John H. Denny	ADDRESS 715 Light St.

IMPORTANT. See instructions on back of certificate. Every statement of OCCUPATION is very important. Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Bks.

E 52201

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Curtis Bay

CITY OF BALTIMORE: (No.) 6216 Pennington Ave ST. WARD 23-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus A Smith

(a) RESIDENCE NO. 6216 Pennington ST. Ave WARD 23

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Smith

6 DATE OF BIRTH (month, day, and year): Oct 2 1846

7 AGE — Years: 83 — Months: 2 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Clarence Smith

(Address) 6216 Pennington ave

15 Filed DEC 21 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1929, to Dec. 18, 1929, that I last saw h alive on Dec. 18, 1929 and that death occurred, on the date stated above, at 2 45 PM

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1.5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H Hoett M. D.

Dec 19 1929 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 21 1929

20 UNDERTAKER: John F Penny — ADDRESS: W Lig St

C 21 1929

FROM a very important point: USE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52202

CERTIFICATE OF DEATH

25 E 52202

1-PLACE OF DEATH Good Shepherd Hospital REGISTERED NO. 1001

City of BALTIMORE: (No. 1512 N. Gilmor St. 19 Ward) 19-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Tolson

(a) RESIDENCE NO. 1924 Druid Hill Av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 23 1869

7 AGE: Years 60 Months 7 Days 26 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm. E. Tolson

11 BIRTHPLACE OF FATHER (City or town) Balt

(State or country) Md.

12 MAIDEN NAME OF MOTHER Luana Tolson.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Chas. Tolson

(Address) 1924 Druid Hill Av

15 Filed ..... 19 .....

DEC 21 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 12-19-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 19 29 to Dec 19 19 29

that I last saw her alive on 12-19- 19 29

and that death occurred, on the date stated above, at 10 am

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted Balto md

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) M. Boyle, M. D.

19 (Address) 1512 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn. Date of Burial: Dec 21 1929

20 UNDERTAKER: Mrs. P. G. Elliott ADDRESS 1725 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E ~~52203~~ 52203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 31 ✓ E 52203

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecelia Hart-

(a) RESIDENCE NO. Oakland Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr-15-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	30	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna M. Halberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 21 1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-21-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Dec 21, 1929, that I last saw her alive on Dec-21, 1929 and that death occurred, on the date stated above, at 1 10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary, Right and Left chest

8 (duration) 5-6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema, tubercular, left 17 (duration) yrs. 6-7 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Trocar and thoracotomy left

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred W Teit, M. D.

19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Md

DATE OF BURIAL 12/21 1929

20 UNDERTAKER C. J. Gahagan Sons

ADDRESS 1318 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

E 52204 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 99-P01 52204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1439 N. Mount St. 15-21 Ward) Registered No.

2-FULL NAME Mary Louise Whittaker,

(a) Residence No. 1439 N. Mount St., Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): May 26, 1929

7-AGE: ✓ yrs. 6 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Herman Whittaker

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): D. C.

14- (Informant) Mary Hollands

(Address) 1439 N. Mount St.

15- Filed DEC 21 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 20, 1929.

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1929, to Dec. 19, 1929, that I last saw her alive on Dec. 19, 1929, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Insanition (acute)

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Quinn, M. D.

(Address) 1507 N. Fulton Ave.

*State Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL DATE OF BURIAL, 19

20-UNDERTAKER: Commissioner Health. ADDRESS

DEC 21 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 52205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 11 ✓ E 52205

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 17-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John G. Binford

(a) RESIDENCE NO. Ruxton. Md ST., WARD Ruxton. Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if foreign birth 61 yrs. 2 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ Eleanor T. Binford

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	61	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker

(b) General nature of industry, business, or establishment in which employed (or employer) Banking

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Charles T Binford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Eleanor Gruner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Help. Records
(Address)

15 Filed 2 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21st 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16th, 1929, to Dec. 21st 1929, 19....,

that I last saw h/a alive on Dec. 21st, 1929

and that death occurred, on the date stated above, at 12 40 A m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Ruxton, Md

.....(duration) ....yrs. ....mos. 5 ds.

18 Where was disease contracted if not at place of death? Ruxton Md

Did an operation precede death? Yes Date of Dec. 17th 1929

Was there an autopsy?

What test confirmed diagnosis? operation

(Signed) Wm M. Debney, M. D.

Dec 26th 1929 (Address) Ruxton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 23 1929
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 52206 [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52206

CERTIFICATE OF DEATH

100-00[redacted]

1—PLACE OF DEATH

REGISTERED NO. 70-69

CITY OF BALTIMORE: (No. 2348 Frederick Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. White

(a) RESIDENCE NO. 2348 Frederick Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma White

6 DATE OF BIRTH (month, day, and year) Feb 18, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	56	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huxter

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs Emma White

(Address) 2348 Frederick Ave

15 Filed DEC 21 1929 C. HARRISON JONES, M. D. By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 to ..., 19 29, to Dec 19 ..., 19 29

that I last saw h[illegible] alive on Dec 19 ..., 19 29

and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar E Travers, M. D.

19 (Address) 1508 Hollins.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 23, 1929.
20 UNDERTAKER	ADDRESS
John J. Cowan & Son.	901 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

E 52207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1529-001

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leona Eva Rolfe

(a) RESIDENCE NO. 828 S. Milton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/7/29

7 AGE	Months	Days	If LESS than 1 day, ...hrs. or ...min.
14 days	→		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Rolfe

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Uebansh

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Joseph Rolfe (Address) 828 S. Milton Ave

15 Filed 2-1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21-29

17 I HEREBY CERTIFY, That I attended deceased from 12-17, 1929, to 12-21, 1929 that I last saw her alive on 12-21, 1929 and that death occurred, on the date stated above, at 8-55 A. m.

The CAUSE OF DEATH* was as follows:

Internal Hydrocephalus
Spina bifida

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Leyko, M. D.

12/21, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Dec 21, 1929

20 UNDERTAKER ADDRESS

D. Stephen J. Dalton Edward A. Kenny

Spec.–7-17-26—A Co.—200 Bks.

E 52208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ # 52205 × +9

E 52208

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gilbert Kelly

(a) RESIDENCE NO. Glyndon Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5-1904

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	20	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Gilbert E. Kelly

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Hester Omeara

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Hospital Records

(Address)

Filed DEC 2 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

12. 22. 29

17 I HEREBY CERTIFY, That I attended deceased from 11-26-29, 19..., to 12-22, 1929, that I last saw him alive on 12-22-29, 19..., and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of chest wall

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary) General Sarcomatosis

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 12-3-29

Was there an autopsy? No

What test confirmed diagnosis? Lab. exam of spec.

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral Cemetery — Date of Burial Dec 24 1929

20 UNDERTAKER J. F. Ebert — ADDRESS Reisterstown Md

DEC 24 1929 [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Amelia L. Wagner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52209

CERTIFICATE OF DEATH

10-001

E 52209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 223 N. Madeira St. 670 (Ward)

2-FULL NAME Amelia L. Wagner

(a) RESIDENCE NO. 223 N. Madeira St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2/1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Wagner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mississipi

12 MAIDEN NAME OF MOTHER Clara Wilhelm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Frank Wagner
(Address) 223 N. Madeira St

15 Filed 19 Registrar

2 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Diphtheria

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History Dr. E.G. Hall

(Signed) [signature] M. D.

2/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Dec. 22 1929

20 UNDERTAKER M. J. & E. Doppel

ADDRESS 37 S Amity

Be sure that all items are answered fully, and that no space is left blank. Data required is important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 52210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52210

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hosp. St., 15-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Louis W. Hoffman Jr.

(a) RESIDENCE NO. 4100 Rollin Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Morris Hoffman

6 DATE OF BIRTH (month, day, and year): April 14, 1885

7 AGE: Years 44 Months 8 Days 7

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis W. Hoffman Sr.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Catherine Clark

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Hospital Records

(Address)

15 Filed DEC 22 1929, 19 HAMILTON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

12-21-29

17 I HEREBY CERTIFY, That I attended deceased from 12-20, 19 29, to 12-21, 19 29, that I last saw h[illegible] alive on 12-21, 19 29, and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) yrs. mos. 2 wks ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 5 min. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Adams Jones M. D.

(Address) 1 W. Mt. Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Dec 23 1929

20 UNDERTAKER: Chas. S. Black — ADDRESS: 742 W. North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52211

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Hope ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Payne Kummer

(a) RESIDENCE NO. 1908 Hope ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Kummer

6 DATE OF BIRTH (month, day, and year) April 10 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Winston Salem
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Haines

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Carl Kummer

(Address) 1908 Hope st

DEC 22 1929

H. WILSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to Dec. 21 at, 1929, that I last saw h[illegible] alive on Dec. 21 at, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Magness, M. D.

12/22, 1929 (Address) 14. E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 24 1929

20 UNDERTAKER Chas. G. Blade ADDRESS 142 W. North ave

Spec.—1-10-21—M&T—1500 Blks.

E 52212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-606 E 52212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 3-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Smeyne

(a) RESIDENCE NO. 2212 Bryant Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
M	White	~~Divorced~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Radio Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Moses Smeyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant M. Smeyne

(Address) 2212 Bryant ave

15

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1929

17

I HEREBY CERTIFY, That I attended deceased from 12/15, 1929, to 12/20, 1929, that I last saw him alive on 12/20, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Rt. lower (Type III)

CONTRIBUTORY (Secondary) Pleurisy, Rt. & Lt. (duration) yrs. mos 6 ds.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum culture; clinical

(Signed) A. J. Gibbs, M. D.

Dec 20 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rest	Dec 22, 1929
20 UNDERTAKER	ADDRESS 1127 E Balto St
Jos Levinson & Bro	

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52213

CERTIFICATE OF DEATH.

90 E 52213

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1627 Moreland Ave (St.) (Ward) 5-68

2-FULL NAME Jennie Brodsky

(a) RESIDENCE NO. 1627 Moreland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Brodsky

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Benjamin Sirlyn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sirlyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Brodsky

(Address) 1903 Wheeler Ave

15 Filed DEC 27 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 1929. to Dec 26 1929.

that I last saw h[illegible] alive on Dec 26 1929.

and that death occurred, on the date stated above, at 930. m.

The CAUSE OF DEATH* was as follows:

Cardio renal disease

5

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. Greenwald. M. D.

Dec 27 1929 (Address) 1809 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 12/31/29

20 UNDERTAKER Jack Lewis 1434 E Baltimore

ADDRESS

DEC 27 1929

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2760 Tivoli (St.) 9-46 (Ward)

2-FULL NAME William E Land.

(a) RESIDENCE No. 2760 Tivoly ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Land.

6 DATE OF BIRTH (month, day, and year) Sept 30. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62.	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Casualty.

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER Joseph Land.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Elizabeth Wilgus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Lillie Land.

(Address) 2760 Tivoly ave.

15 Filed DEC 22 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1929, to Dec 20, 1929, that I last saw him alive on Dec 20, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 2858 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec. 23 1929.

20 UNDERTAKER Mr. & Mrs. John H. Pfeffer Son — ADDRESS 801 W. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52215

CERTIFICATE OF DEATH

129

E 52215

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Homeland ST. 27-48 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William G. Streett

(a) RESIDENCE NO. 421 Homeland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lollie Streett

6 DATE OF BIRTH (month, day, and year) Jun. 3, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postal Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER Kennedy Streett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Tate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Lollie Streett

(Address) 421 Homeland St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1925, to Dec 20, 1929, that I last saw h[illegible] alive on Dec 20, 1929, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Ch. Int. Nephritis - Ch. Myocarditis.

Endarteritis 1 yr leg.

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. V. Bishop, M. D.

Dec 21, 1929 (Address) 501 Rhinelander

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Park Wood Cemetery	Dec 22 1929
20 UNDERTAKER John F. Dennis	ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52216

CERTIFICATE OF DEATH

57

E 52216

1—PLACE OF DEATH

REGISTERED NO. 15-58

CITY OF BALTIMORE: (No. Pimlico Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Ellsworth Busch

(a) RESIDENCE NO. 4636 Park Heights Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver F. Busch

6 DATE OF BIRTH (month, day, and year) June 10 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Slater

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary E. McCulloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Edna Busch

(Address) 4636 Park Heights Ave

15 Filed DEC 2 1929 19 H. WINSLOW JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Dec. 21, 1929, that I last saw h[illegible] alive on Dec 20, 1929 and that death occurred, on the date stated above, at 1 a, m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Gangrene -

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) M. S. Gilroy - M. D.

. 19 (Address) 6 W. Read St -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 23 1929
20 UNDERTAKER	ADDRESS
Chas. S. Denny	1 S. Eutaw

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

13/B 52217

CERTIFICATE OF DEATH

37-001 B 52217

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. JOHNS HOPKINS HOSPITAL ST 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Butler

(a) RESIDENCE NO. 134 East— ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred L yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md—

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliz. Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md—

14 Informant Friends—

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1929 H. HANSON JONES, M. D. Registrar

C 27923 film

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25-29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Dec 20, 1929, that I last saw him alive on Dec 20, 1929, and that death occurred, on the date stated above, at 4 35A m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Primary ?

Duration

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes —

What test confirmed diagnosis?

(Signed) Benjamin E. Hodge, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: 12-28 1929

20 UNDERTAKER: Byron Wright

ADDRESS: 1218 N. Gilmor St

Spec.—2-25-28—L. F. S.—600 Bks.

B 2-3-22 1/8

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 32 ✓ E 52218

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary McClure

(a) RESIDENCE NO. Box 18 - Washington N-C STR. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? 2 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14 - 1927

7 AGE: Years 2 | Months 3 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ga -

PARENTS

10 NAME OF FATHER Hugh McClure

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga -

12 MAIDEN NAME OF MOTHER Lucile Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga -

14 Informant: Parents -

(Address)

15 Filed DEC 22 1929 PHILIP JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 - 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Dec 22, 1929, that I last saw h[illegible] alive on Dec 22, 1929 and that death occurred, on the date stated above, at 7 a - m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington N.C.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) Benjamin E. Hodge M. D.

. 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany Ga.

DATE OF BURIAL: Dec 23 1929

20 UNDERTAKER: John O. Middleton

ADDRESS: Race Street

Spec.—8-16-29—L. F. S.—100 Bks.

E 52219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 52219

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 N. Charles ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth L. O'Neill

(a) RESIDENCE NO. 901 N. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9y yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ~~~~

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 70	—	—	"

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John O'Neill

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Lynch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Ella O'Neill
(Address) 901 N. Charles Street

15 Filed 12 29 1929, 19 ... C. P. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20/29

17

I HEREBY CERTIFY, That I attended deceased from 12/10, 1929, to 12/20, 1929, that I last saw h[illegible] alive on 12/20, 1929 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

General Arteriosclerosis

(duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Obvs. Examination

(Signed) John T Shaw M. D.

12/24 1929 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/23 1929
20 UNDERTAKER Henry C. Mears & Son	ADDRESS 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 52220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135

E 52220

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... St., 14-20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Cobleus

Madei - Wilson

(a) RESIDENCE NO. Plymouth Road WARD 20th.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 29 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70 yrs	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Daniel Cobleus

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina —

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany.

14 Informant Dan'l Joseph

(Address) 1513 Eutaw Place

Filed 12 2 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/2 ....., 19 29 , to 12/21 ....., 19 29 ,

that I last saw him alive on 12/21 ....., 19 29 ,

and that death occurred, on the date stated above, at 4 A.M. .m.

The CAUSE OF DEATH* was as follows:

(1) Pulmonary oedema

(2) Pyelonephritis (Acute, Bilateral) Nephritis.

(duration) ..... yrs. (1) - 2 days mos. Tadeo

CONTRIBUTORY (Secondary) Hypertension - Benign

(duration) ..... yrs. Unknown ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & P. M.

(Signed) ..... M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Emet — DATE OF BURIAL 12/23 1929

20 UNDERTAKER Isaac Sonnheim — ADDRESS 10-20 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 52221

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 25-72 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thelma Wheeler

(a) RESIDENCE NO. 2120 Wicomico st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Wheeler

6 DATE OF BIRTH (month, day, and year) March 2, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	25	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer At Home ~~Unknown~~

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Philip Niser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed DEC 22 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to Dec. 20, 1929, that I last saw her alive on Dec. 20, 1929 and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas. Thomas Jr. M. D.

12-20, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec. 23 19 29

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52222

CERTIFICATE OF DEATH

90 E 52222

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3810 Roland Ave ST., 13 (WARD)

2—FULL NAME Richard A. Lindsay

(a) RESIDENCE NO. 3810 Roland Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 7 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Lindsay

6 DATE OF BIRTH (month, day, and year) April 24 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 4 years

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Archabald Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Joice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss. Carrie Lindsay

(Address) 3810 Roland Ave

15 Filed 12 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19-1929.

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929. to Dec 19, 1929

that I last saw him alive on 12/18, 1929

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Ch. myocarditis

(duration) several yrs.

CONTRIBUTORY (Secondary) Age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward H. , M. D.

12/21, 1929 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Dec. 23 1929.
20 UNDERTAKER	ADDRESS
Horace H. Burgee	3621 Falls Road

Spec.—1-12-23—M&T—500 Blo.

E 52223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52223

CERTIFICATE OF DEATH.

75-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1214 Madison St. (Ward) 4th

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Lee Mitchell

(a) RESIDENCE NO. Wilmington, Del. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James

6 DATE OF BIRTH (month, day and year) ? 1889

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant James Mitchell

(Address) 1214 Madison Ave

15 Filed 2 2 1929, 19

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to Dec. 21, 1929, that I last saw her alive on Dec. 21, 1929, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

1 (duration) — yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Traumatism from fall Operation (duration) 3 yrs. ago mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1926

Was there autopsy?

What test confirmed diagnosis? Paralysis one side

Signed H. C. Montague, M. D.

, 19 (Address) 1214 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington, Del. DATE OF BURIAL 12/24/1929

UNDERTAKER Wm. Geo. H. Holland ADDRESS 1631 Dueg St

Spec.—2-29-28—L. F. S.—500 Blks.

2 8 2 2 5 — E 32224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

59 ✓ E 32224

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ira Garst

(a) RESIDENCE NO. Hollins - Va ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Catherine

6 DATE OF BIRTH (month, day, and year): June 14-1897

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
32	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va —

PARENTS

10 NAME OF FATHER: Allen Garst

11 BIRTHPLACE OF FATHER (city or town) (State or country): Roanoke Co Va.

12 MAIDEN NAME OF MOTHER: Rosa Showalter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Roanoke Co Va

14 Informant: Friends —
(Address)

15 Filed DEC 23 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec-22-29

17 I HEREBY CERTIFY, That I attended deceased from Dec-19, 1929, to Dec 22, 1929, that I last saw him alive on Dec-22, 1929 and that death occurred, on the date stated above, at 12 15 P m.

The CAUSE OF DEATH* was as follows:

Hypernephroid Tumor

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/21/29

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic & Autopsy

(Signed) Clarence A Gardner M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Roanoke Va — DATE OF BURIAL: Dec 23 1929

20 UNDERTAKER: Hughes & Foreshee — ADDRESS: 424 N Bd

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52225

CERTIFICATE OF DEATH

167-001 E 52225

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Sq Hosp St. 10-27 (Ward)

2-FULL NAME Russell F. Forbes

(a) RESIDENCE NO. 1922 W. Saratoga St., Ward 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) March 15-1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Millard F. Forbes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N C

12 MAIDEN NAME OF MOTHER Nancy P. Gilbert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N C

14 Informant Paul R Forbes
(Address) Bradley S C

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide by illuminating Gas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke, M. D.

, 19 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Va	12/22/29

20 UNDERTAKER George C Fraley ADDRESS Fulton Augusta

DEC 23 1929

IMPORTANT—Physicians are requested to write plainly, in ink, and to report all the facts required by this certificate. Certificate of Death cannot be issued by Registrar of Vital Statistics unless Cause of Death is given in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52226 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52226

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 4 Ward)

2-FULL NAME Cora M. Wildasin.

(a) RESIDENCE NO. 1623 E. 31st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur L. Wildasin

6 DATE OF BIRTH (month, day, and year) Jan 16—1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Adams Co (State or country) Penna

PARENTS

10 NAME OF FATHER Levi Conbaugh

11 BIRTHPLACE OF FATHER (city or town) Carroll Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Shildt

13 BIRTHPLACE OF MOTHER (city or town) Adams Co (State or country) Penna

14 Informant Arthur L. Wildasin (Address) 1623 E. 31st St. Old Gate End

15 Filed DEC 23 1929 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929. to Dec. 22, 1929. that I last saw her alive on Dec. 22, 1929, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings.

(Signed) N. M. Wildasin M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littlestown Pa — DATE OF BURIAL Dec 26 1929

20 UNDERTAKER John R. Little — ADDRESS Littlestown Pa

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52227

HEALTH DEPARTMENT—CITY OF BALTIMORE

78 ✓ E 52227

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Loretta Elizabeth Yakel

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 4 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug 14, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	55	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Anthony Yakel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hesse Germany

12 MAIDEN NAME OF MOTHER: Bernadina Weitkemper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Westphalen Germany

14 Informant: Mt Hope Records

(Address): Mt Hope Retreat

15 Filed C 2 3 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 21. 1929

17 I HEREBY CERTIFY, That I attended deceased from August, 1925, to Dec. 21, 1929, that I last saw h[illegible] alive on Dec 20, 1929 and that death occurred, on the date stated above, at 4.17 p.m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 20 yrs. unknown mos. ds.

CONTRIBUTORY (Secondary): Enteritis

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 23 19 29
UNDERTAKER: Wm J Tuckner Son	ADDRESS N 4 Pa.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52228

CERTIFICATE OF DEATH

74-001
E 52228

1-PLACE OF DEATH

City of Baltimore: (No. 2849 Prospect St. 16-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm B. Flinn

(a) RESIDENCE No. 2849 Prospect St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie E.

6 DATE OF BIRTH (month, day, and year) Jan 23, 1860

7 AGE: Years 69 | Months 10 | Days 28 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) 078
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) "

PARENTS

10 NAME OF FATHER Thos Flinn

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Rouzer

13 BIRTHPLACE OF MOTHER (city) Va
(State or country) "

14 Informant John F. Flinn
(Address) 2849 Prospect

Filed DEC 23 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy (duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) ..... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem | DATE OF BURIAL: Dec 23 1929

UNDERTAKER: Wm Fickner & Sons | ADDRESS: N. & Pa

IMPORTANT. See instructions on back of certificate. Be careful to fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

SNYDER

HEALTH DEPARTMENT—CITY OF BALTIMORE

52229

CERTIFICATE OF DEATH

129 ✓ E 52229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 906 Homewood Ave St. 10-14 Ward)

2-FULL NAME Christian Snyder

(a) RESIDENCE NO. 906 Homewood Ave St., Ward

(Usual place of abode) 15 yrs

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
✓ About 53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Probably
(State or country) Washington, Pa.

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Health Dept Records of Sister Lucy Spears
(Address)

15 Filed 12/31/29 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Hall, M. D.

12/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cem — DATE OF BURIAL 1/3/29, 19

20 UNDERTAKER George J. Ruth — ADDRESS 1331 Hart

IMPORTANT. See instructions on back of certificate. Be certain to write in plain terms, so that it may be properly examined. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52230

CERTIFICATE OF DEATH

51 ✓

E 52230

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 735 W Hamburg St. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida May Hess

(a) RESIDENCE NO. 735 N Hamburg ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elmer B Hess

6 DATE OF BIRTH (month, day, and year): May 10 1908

7 AGE: Years 21 | Months 4 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo Pfeifer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lillian B Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Elmer B Hess

(Address) 735 N Hamburg St

15 Filed DEC 29 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-20-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 19 29 to Dec 20 19 29 that I last saw h[illegible] alive on Dec 20 19 29 and that death occurred, on the date stated above, at 9 50 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Int Obstruction

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirm[illegible] diagnosis?

(Signed) Shepherd Brown, M. D.

19 (Address) 127 Mosher Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk Cem.

DATE OF BURIAL: 12-23 1929

20 UNDERTAKER: Bernard C Harlan

ADDRESS: 1000 E Pratt St.

Cor.—10-10-20—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-002

E 52293

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1910 McCulloh St. 14-20 Ward)

2-FULL NAME Frank Bookal

(a) RESIDENCE NO. 1910 McCulloh St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosie

6 DATE OF BIRTH (month, day, and year): March 1891 3/6/91

7 AGE: Years 38 | Months 9 | Days 11 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O&O
(c) Name of employer

9 BIRTHPLACE (city or town): Ohio
(State or country)

PARENTS

10 NAME OF FATHER: Unk

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Rosa Bookal
(Address): 1910 McCulloh

Filed DEC 23 1929 H. M. JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day) and year) Dec 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.

Dec 21 (Address) McCulloch Corner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 23 29
20 UNDERTAKER: Thomas E. Kelson	ADDRESS: 1303 Pennsylvania

Do not write in this space. Use pencil. Fill in all blanks, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Pipes

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52232

CERTIFICATE OF DEATH.

24-001 E 52232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 N. Stricker ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Pipes

(a) RESIDENCE. No. 1102 N. Stricker ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	—	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Md

PARENTS

10 NAME OF FATHER Frederick Pipes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

11 Informant Anne C. Travers

(Address) 1102 Stricker St

15 Filed DEC 23 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1929 to Dec 21 1929, that I last saw her alive on Dec 21 1929, and that death occurred, on the date stated above, at 3,30 p. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. 8 mos. 21 ds.

Arteriosclerosis

(duration) yrs. 3 mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical symptoms

(Signed) Charles H. Frowell M. D.

Dec 24 1929 (Address) 712 S. Stark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 23 1929

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Hund Hill

THIS is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 52233

CERTIFICATE OF DEATH.

E 52233

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1406 E Monument St. 10-13 WARD)

2-FULL NAME Chester Dobson

(a) RESIDENCE No. 1406 E. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Dobson

6 DATE OF BIRTH (month, day, and year) Feb - 6 - 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooler Oil

(b) General nature of industry, business, or establishment in which employed (or employer) Natural

(c) Name of employer Cosden Co —

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Virginia

PARENTS

10 NAME OF FATHER John Dobson

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rosie Minor

13 BIRTHPLACE OF MOTHER (city or town) Fredericksburg (State or country) Virginia

14 Informant Edith Dobson

(Address) 1406 E Monument

15 Filed DEC 23 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 20 1929

17

I HEREBY CERTIFY, That I attended deceased from July - 10, 1929 to Dec 20, 1929.

that I last saw him alive on Dec 20 1929.

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic aneurysm

(duration) — yrs. 6 mos + ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Dr @ hospital

(Signed) Dan Trunkey M. D.

12/21/1929 (Address) 1111 E Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Dec 24, 29

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Eutaw Pl

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52234

CERTIFICATE OF DEATH.

3 1 E 52234

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2026 Ridge Hill Ave ST. 15-21 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. McGee

(a) RESIDENCE NO. 2026 Ridge Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine McGee

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Matthew McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine McGee

(Address) 2026 Ridge Hill Ave

Filed 2-3-1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 1929

17

I HEREBY CERTIFY, That I attended deceased from June, 1929, to Dec 20, 1929,

that I last saw him alive on Dec 20, 1929,

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

a Pulmonary Tuberculosis

Duration of case

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

12/23, 1929 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL 12/23 1929

20 UNDERTAKER: W. Cook — ADDRESS 1217 W Fayette St

Spec.—2-29-28—L. F. S.—500 Blks.

Spelmkouch ✓

E 52235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

27-001

E 52235

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1430 Poplar Grove ST., 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Spelmkonch

(a) RESIDENCE NO. 1430 Poplar Grove ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed,~~ or Divorced ~~(write the word)~~: Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~C~~

6 DATE OF BIRTH (month, day, and year): Aug 21 1871

7 AGE: Years 58 | Months 4 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Spelmkonch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Kunselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William Spelmkonch (Address) 1430 Poplar Grove

15 Filed 12-31-1929 19 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 22- 1929 to Dec 22 1929 that I last saw h[illegible] alive on Dec 22 1929 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. J. Keller, M. D.

12/31 1929 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemy	Dec 24 1929
20 UNDERTAKER: Jos Joerdens Son	ADDRESS: 2078 Pen

Spec.—2-29-28—L. F. S.—500 Blks.

E 52236 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH

129 E 52236

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. 3-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Hemsley

(a) RESIDENCE NO. 413 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ?yrs. ?mos. ?ds. How long in U. S., if foreign birth? -yrs. -mos. -ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Hemsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mollie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 19 C. H. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-20-29

17 I HEREBY CERTIFY, That I attended deceased from 12-3-29, 19..., to 12-20-29, 19..., that I last saw him alive on 12-20-29, 19..., and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with edema.

more than 1 yrs. ... mos. ... ds.
(duration)

CONTRIBUTORY (Secondary) Uraemia + bronchopneumonia

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy, clinical exam.

(Signed) Marvin M. McLean, M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL [illegible] 24 1929

20 UNDERTAKER Milton Davis

ADDRESS 413 N Eden St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52237

CERTIFICATE OF DEATH

40 V

E 52237

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. St., 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Thomas

(a) RESIDENCE NO. 1014 N. Eutaw ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	65?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Henry Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Hospital Record
(Address)

15 Filed 2 31929 19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-18-29

17 I HEREBY CERTIFY, That I attended deceased from 12-14, 1929, to 12-18, 1929, that I last saw h[illegible] alive on 12-18, 1929 and that death occurr[illegible] on the date stated above, at 7 P. m.

The CAUSE OF D[illegible] was as follows:

Urethral Stricture

Chronic Urinary retention

(duration) Unknown

CONTRIBUTORY (Secondary) Pyelonephritis & [illegible]

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. A. Lumpkin, M. D.

12-19-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 12-23 1929

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1[illegible] W. Hamburg St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52238 14 E 52238

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 10-14

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Lydill

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29th 1936

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	93	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Sigmond Fliegil

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elij. Gaspar

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor
(Address) Preston + Valley

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 23rd Dec 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 23, 1929, that I last saw h[illegible] alive on Dec 21, 1929 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Benson Woods, M. D.

Dec 23. 1929 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 24 1929

20 UNDERTAKER Rita Niedefuhr ADDRESS 914 Gaumont Ave

Spec.—2-29-28—L. F. S.—500 Blks.

32297 E 32239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 32239

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Webster

(a) RESIDENCE NO. 2571 E. Biddle ST., WARD Deals Island.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 1 Year(s) 10 Months 22 Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Truman Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Anna White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address):

15 Filed DEC 28 1929 H. Wesley JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec-22-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 22, 1929, that I last saw her alive on Dec 22, 1929 and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clarence E. Gardner M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deals Island Md — DATE OF BURIAL: 12/23/1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52240

CERTIFICATE OF DEATH

84 ✓

E 52240

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 510 N. Arlington Ave (St.) (WARD) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Annie M. Peddicord

(a) RESIDENCE NO. 1804 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W. | 5 ~~Single, Married,~~ Widowed, or ~~Divorced,~~ (write the word) Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T. Peddicord

6 DATE OF BIRTH (month, day, and year) Jan 4-1852

7 AGE | Years 77 | Months 11 | Days 18 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mary Handy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Handy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Louis Gt

(Address) 1804 W Lombard St

15 Filed DEC 29 1929, 19.. C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22-29

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1928, to Dec 22, 1929, that I last saw h[illegible] alive on Dec. 12, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Neuro Fibroma. of brain

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

Dec 23 29 (Address) 612 N 40 A T

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park | DATE OF BURIAL Dec 24-29

20 UNDERTAKER Pentland & Gore | ADDRESS 1723 W Lafayette Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52241

CERTIFICATE OF DEATH

100-001

E 52241

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Maryland Penitentiary WARD) 10-18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Collins

(a) RESIDENCE NO. Maryland Penitentiary WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15 Filed 12-20 19 29 Registrar

JOHNS HOPKINS HOSPITAL, M. D.

THE MORGUE 4188

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Dec 19, 1929, that I last saw him alive on Dec 18, 1929, and that death occurred, on the date stated above, at 12 05 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Asthma 5 weeks

Acute Bronchitis (duration) one week, yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. Typical findings

(Signed) Joshua H Adamscott, M. D.

Dec 19, 1929 (Address) Woodlawn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 23 1929

20 UNDERTAKER Commissioner Health

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 52242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3

E 52242

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 524 Carmel St., 11-24 Ward)

2-FULL NAME Jas Lewis.

(a) RESIDENCE NO. 524 Carmel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF ~~BIRTH~~ (month, day, and year) about 1879

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant
(Address)

15 Filed ..., 19.. H. H. JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an 6
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) ..yrs. 6 mos. ..ds.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted
If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Jones, M. D.

Dec 19th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS DEC 23 1929

DEC 23 1929 THE MORGUE 4189

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52243 ✓ 89 E 52243

CERTIFICATE OF DEATH

E 52243

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2806 Garrison Ave. ST. 15-6L (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Cook Schott

(a) RESIDENCE NO. 2806 Garrison Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Schott

6 DATE OF BIRTH (month, day, and year) June 30, 1875

7 AGE	Years	Months	Days 20	If LESS than 1 day, hrs. or min.
	54	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER ----- Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) -----

14 Informant Conrad Schott

(Address) 2806 Garrison Ave.

15 Filed Dec 29 1929 C. H. [illegible] JONES M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20. 29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1929, to Dec 20, 1929, that I last saw h[illegible] alive on Dec 20, 1929, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Failure -

(duration) yrs. mos. 24 hours ds.

CONTRIBUTORY (Secondary) Angina Pectoris. attack 2 minutes - several years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) G Carroll Lockard M. D.

Dec 23 1929 (Address) 4 E. Preston St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec. 30, 29

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mathew P. Mitchell

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52244

CERTIFICATE OF DEATH

74-008 52244

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 302½ - 23rd ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Stewart

(a) RESIDENCE NO. 302½ - 23rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lucconac Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joanna Mitchell

(Address) 302½ 23rd

DEC 23 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 20, 1929, that I last saw h.r. alive on Dec 20 1929 1 pm and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) General Condition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) H. D. Hall, M. D.

, 19 (Address) 4626 23rd Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn

DATE OF BURIAL: 12/23/29

20 UNDERTAKER: Samuel Hensley

ADDRESS: Balto

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52245 ✓ 57 E 52245

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary WARD) 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl Brown

(a) RESIDENCE NO. Maryland Penitentiary WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Burton Brown

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oysterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles County Maryland

PARENTS

10 NAME OF FATHER James W. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nanticoke Maryland

12 MAIDEN NAME OF MOTHER Kate Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newberg Maryland

14 Informant Md Penitentiary Records

(Address) Baltimore Md

15 Filed DEC 29 1929, HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929, to Dec 22, 1929, that I last saw him alive on Dec 21, 1929 and that death occurred, on the date stated above, at 9.19 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Alcoholism Jaundice

(duration) 6 yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Osborne A Brownscombe, M. D.

Dec 27 1929 (Address) Woodlawn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 23 1929

20 UNDERTAKER Commissioner Health.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 52246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 90 E 52246

1—PLACE OF DEATH Provident Hospital

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. 1514 Druid ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Lewis

(a) RESIDENCE NO. Oakdale Rd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	48	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) Provident Hospital

15 Filed DEC 23 1929 H. J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 22, 1929, that I last saw h[illegible] alive on Dec 22, 1929, and that death occurred, on the date stated above, at 7 22 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Cardiovascular Disease

(duration) about yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

12-23, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va.

DATE OF BURIAL 12/20/1929

20 UNDERTAKER Geo. H. Holland

ADDRESS 1631 Druid Hill

Spec.—2-29-28—L. F. S.—500 Bks.

E 52247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 52247

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2450 Ellwood St ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas C Dorsey

(a) RESIDENCE NO. 2450 Ellwood St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 29-1894

7 AGE: Years 35 Months 7 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of Industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Penman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Annie Dorsey

(Address) 215 N Eutaw St

15 Filed DEC 23 1928 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929 to Dec 21, 1929, that I last saw him alive on Dec 21, 1929 and that death occurred, on the date stated above, at 9 15 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General weakness

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) S. F. Hall, M. D.

19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: 12/24 1929

20 UNDERTAKER: Chas. H. Johnson

ADDRESS: 446 N. Carolina St.

Spec.—8-16-29—L. P. S.—100 Blks.

E 52248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 52248

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 W Lombard ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Mulroy.

(a) RESIDENCE NO. 1216 W. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mulroy.

6 DATE OF BIRTH (month, day, and year) June 4-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 88

(b) General nature of industry, business, or establishment in which employed (or employer) Street cleaning dept

(c) Name of employer City.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick Mulroy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Byrne.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Mary Mulroy

(Address) 1216 W Lombard St.

15 Filed AUG 23 1929 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21, 1929.

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to Dec. 21, 1929, that I last saw h alive on Dec. 21, 1929 and that death occurred, on the date stated above, at 2:55 p. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1927

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. T. Dripert, M. D.

19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Dec 24th 1929

20 UNDERTAKER John J. Cowan & Son.

ADDRESS 901 Holliday St

Spec.—2-29-28—L. F. S.—500 Blks.

23 22 93
E 52249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 V

E 52249

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Priscilla Wilson

(a) RESIDENCE NO. 918 Harlem ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) Md -
(State or country)

PARENTS

10 NAME OF FATHER Philip Wilson

11 BIRTHPLACE OF FATHER (city or town) Md -
(State or country)

12 MAIDEN NAME OF MOTHER Zilla Thornton

13 BIRTHPLACE OF MOTHER (city or town) La -
(State or country)

14 Informant Records -
(Address)

15 Filed Dec 28 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22-29

17

I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 22, 1929, that I last saw h[illegible] alive on Dec 22, 1929 and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pleural effusion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Benjamin E. Hodge, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 23, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 3221 Schroeder St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52250 | 143 | E 52250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5636 Oxford St., 17-24 Ward)

2-FULL NAME Eugene S. Burgess

(a) RESIDENCE NO. 5636 Oxford St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 30-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Walter S. Burgess

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Burgess

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Bessie Burgess
(Address) 5630 Oxford

15 Filed OCT 23 1929 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

(Address) Oct 29/29 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-24 1929
20 UNDERTAKER Harold Corbin	ADDRESS 916 Park Ave

IMPORTANT—Before burial, cremation or removal of body, this certificate must be filed with the Registrar of the district in which death occurred. Burial permit will be issued by him, or by the property custodian. Extra certificates may be procured from him. Fill out all items in ink, so that it may be read clearly in making copies. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 52251 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 90 E 52251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7000 Reisterstown Rd. ST.) (WARD) 27-55

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida L. Becker (Becker)

(a) RESIDENCE No. 7000 Reisterstown Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Becker

6 DATE OF BIRTH (month, day, and year) Oct 21- 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joshua Zimmerman

11 BIRTHPLACE OF FATHER (city or town) ~~Baltimore~~ (State or country) Maryland

12 MAIDEN NAME OF MOTHER ~~Elizabeth Spooner~~

13 BIRTHPLACE OF MOTHER (city or town) ~~Baltimore~~ (State or country) Frederick County, Md.

14 Informant Charles Becker

(Address) 7000 Reisterstown Road

15 Filed DEC 23 1929, 19

G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 - 1929, to Dec 22 1929, that I last saw her alive on Dec 22 1929, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Several years yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) E. E. Nichols, M. D.

12/23 1929 (Address) Parkville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Dec. 24 1929

20 UNDERTAKER Joseph H Cook

ADDRESS 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52252

CERTIFICATE OF DEATH

91-09 E 52252

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (No. Lombard & Eight St. 26-37 Ward)

2-FULL NAME Jos Cummings

(a) RESIDENCE Lombard & Eight St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 Color or Race W | 5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 68 | Months | Days | IF LESS than 1 day ..... hrs. ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Patrick Cummings

11 BIRTHPLACE OF FATHER (city or town) Ire
(State or country)

12 MAIDEN NAME OF MOTHER Mary Cummings

13 BIRTHPLACE OF MOTHER (city or town) Ire
(State or country)

14 Informant Mary Cummings
(Address) 26 N Belnord Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

DEC 23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 6 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —
Was an operation performed? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Exam.

(Signed) G E Blades, M. D.

19 (Address) 1436 Piney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patricks Balto — DATE OF BURIAL 12/24/29

20 UNDERTAKER J J Moan — ADDRESS 300 Balto St

IMPORTANT—Fill in plainly, and use ink if any of the printed items are not applicable. Be sure to fill in DATE OF DEATH in plain terms, as this is many times the most important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52253

CERTIFICATE OF DEATH

185 E 52253

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Lotty Hospital St. 6-11 Ward)

2-FULL NAME Matilda H. Evans

(a) RESIDENCE NO. 1626 Ellwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed or Divorced. (write the word): Widow

3a If married, widowed or divorced (or) WIFE of: John H. Evans

6 DATE OF BIRTH (month, day, and year): Sept 1865

7 AGE: Years 64 | Months 3 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Virginia

PARENTS

10 NAME OF FATHER: Milton Baber

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Hinman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Virginia

14 Informant (Address): Cath. Hagner 1626 Ellwood

15 Filed 2 3 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Fracture of Hip

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Evans M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Lawn

DATE OF BURIAL: 12/23 1929

20 UNDERTAKER: J. J. Moran

ADDRESS 300 Balto.

Op. DEATH in plain terms, so that it may be properly classified. Each statement of fact is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(Brejcha)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52254

91-002

E 52254

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2116 Cambridge St. 1-3 Ward)

2-FULL NAME Anna Brejcha

(a) RESIDENCE NO. 2116 Cambridge St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Brejcha

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	71			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 637
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Thomas Brejcha

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Joseph Kocka
(Address) 2116 Cambridge St

15 Filed C. HAMPSON JONES, M. D. Registrar

2 3 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? By History

(Signed) [illegible], M. D.

, 49 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 27 1929
20 UNDERTAKER Fred Brockton 1906	ADDRESS Eastern Ave

IMPORTANT—Fill out this certificate in plain terms, so that it may be properly classified. Each statement of occupation is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52255 E 52255

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3638 S. Hanover St. 25-75 WARD.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Marshall Sr.

(a) RESIDENCE. No. 3638 S. Hanover St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Byus

6 DATE OF BIRTH (month, day, and year) Sept. 3rd 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	73	3	17	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John H. Marshall

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Evans

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Mr. Jos. Marshall Jr.
(Address) 3638 S. Hanover St.

15 Filed DEC 31 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Dec 21, 1929, that I last saw h[im] alive on Dec 21, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks M. D.

Dec 22 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	12/31/ 1929
20 UNDERTAKER	ADDRESS
J. J. Fanning & Son	1938 E. Lafayette Ave

THIS is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52256

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1019 William ST. 24-33 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry H. Hamlen

(a) RESIDENCE NO. 1019 William ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sarah Hamlen

6 DATE OF BIRTH (month, day, and year) May 4 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) O&S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Alfred Hamlen

(Address) 1019 William St

15 12 31 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/17/29, 19..., to Dec 21, 19 29, that I last saw him alive on Dec 21, 19 29 and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mitchell M. D.

12/23 1929 (Address) 1299 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec 24 19 29

20 UNDERTAKER John H. Penny

ADDRESS 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32257 — 88-001 — E 32257

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St., 9-46 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma A Evans

(a) RESIDENCE NO. 503 E. 29 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Richard F. Evans

6 DATE OF BIRTH (month, day, and year): April 11 1905

7 AGE: Years 24 Months 8 Days 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Ennedel Cove Md

(State or country)

PARENTS

10 NAME OF FATHER: Edward J Janson

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER: Annie Holst

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Wilhelmine Janson

(Address) Annedel Cove

Filed 3 1929 G. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract Skull

Auto by which the Riding Collected with Standing Freight Car

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Concussion Cheer

(Duration) yrs mos. ds.

12 (Signed) G. Hampson Jones M. D.

23. 19 (Coroner) (Address) 2939 W. Eden Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Date of Burial: Dec 24 1929

20 UNDERTAKER: John F. Denny ADDRESS: 715 Lex St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52258

CERTIFICATE OF DEATH

48 E 52258

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 306 N. Fulton Ave ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Tanner Mentz

(a) RESIDENCE NO. 306 N. Fulton Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mentz

6 DATE OF BIRTH (month, day, and year) June 14th 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Ernest Tanner

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Henzel

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant John Mentz

(Address) 306 N Fulton Ave

15 Filed 2 3 1929 C. HAMPSON JONES, M. D. Registrar

Reg. 2258

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22/29

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 22, 1929, that I last saw her alive on Dec 22, 1929, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia, both bases

Cancer of Breast Carcinoma (duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? (own)

Did an operation precede death? yes Date of about 1 year

Was there an autopsy? yes

What test confirmed diagnosis? Microscopic

(Signed) W. R. Lucas, M. D.

1/2/30 19 (Address) 3521 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	12/25/29
UNDERTAKER	ADDRESS
H. S. Wyand	1850 N. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52259

CERTIFICATE OF DEATH

90 E 52259

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1448 Reynolds ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Baker

(a) RESIDENCE NO. 1448 Reynolds ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas J Baker

6 DATE OF BIRTH (month, day, and year) Feb 22 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	75	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lebanon
(State or country) Penn.

PARENTS

10 NAME OF FATHER Israel Gruber

11 BIRTHPLACE OF FATHER (city or town) Lancaster
(State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Ellinger

13 BIRTHPLACE OF MOTHER (city or town) Lancaster
(State or country) Pa

14 Informant Elizabeth Brady daughter
(Address) 1448 Reynolds

15 FILED DEC 23 1929, 19 C. HAMPSON JONES, M. D.
By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 19 29 to Dec. 22, 19 1929
that I last saw her alive on Dec 21, 19 29
and that death occurred, on the date stated above, at 730 P. m.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

6
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos J. A. Stevens M. D.
12/27/29 (Address) 2878 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Pa.

DATE OF BURIAL 12/26/ 1929

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul st

Spec.—8-16-29—L. F. S.—100 Blks.

E 52260

HEALTH DEPARTMENT—CITY OF BALTIMORE

153 E 52260

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Bell

(a) RESIDENCE NO. 634 Wyatt ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emory Bell

6 DATE OF BIRTH (month, day, and year) Jan 10 1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md. Balto.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Konfmon

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Schaefer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Helen Applegarth
(Address) 638 Wyatt St

15 Filed ..... 19 ..... H. V. TON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22-29

17 I HEREBY CERTIFY, That I attended deceased from 11-15 19 29, to 12-22 19 29, that I last saw her alive on 12-22 19 29 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Suppurative Cellulitis Right Arm (Cont)

CONTRIBUTORY (Secondary) Septicaemia (duration) ... yrs. 1½ mos. ... ds.

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 12-13-29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

12/22 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 12/26 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217½ Pond St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52261

CERTIFICATE OF DEATH

1855 E 52261

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 16-22 Ward)

2-FULL NAME Eva M. Blank

(a) RESIDENCE NO. 1033 N. Fulton Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Blank

6 DATE OF BIRTH (month, day, and year) July 16-1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	75	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Zellers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Endsor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wm. Blank
(Address) 1033 N. Fulton Ave

15 Filed ....., 19 .....

C. HARRISON JONES, M.D.
Registrar

C 2 31 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture - right femur

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1033 N. Fulton Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Augustus Zellers, M. D.

12-23 1929. (Address) 2729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12-26 19
20 UNDERTAKER Wm Cook 1217	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Dr Blades 143 N Broadway & Fayette Wolf 4020

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32262

CERTIFICATE OF DEATH

185

E 32262

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 621 Grundy St. 26-37 Ward

2-FULL NAME Lois Amelia Walsh

(a) RESIDENCE NO. 621 Grundy St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 23rd 1924

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
5		29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos J. Walsh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Gladys E. Morris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Mrs Gladys E Apostol
(Address) 621 Grundy St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

2-3-1929 By ....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Meninges Fall down Stairs

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Phy Ex & History

(Signed) W. C. Blades, M. D.

19 29 (Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	12/24/1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St. Paul St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Smith)

E 52263

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52263

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2446 Mc Culloh ST. 13-59 WARD

2-FULL NAME Julia Smith

(a) RESIDENCE NO. 2446 Mc Culloh ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Smith

6 DATE OF BIRTH (month, day, and year): 1849.

7 AGE: Years 80 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anderson

14 Informant (Address): Tom Smith 2446 Mc Culloh St

FILED 2 3 1929, 19 ..... E. HAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/24/1929.

17 I HEREBY CERTIFY, That I attended deceased from 11/20/, 19 29. to 12/24, 19 29.

that I last saw h[illegible] alive on 12/21, 19 29.

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis yrs. mos. ds.

18 Where was disease contracted if not at place of death? Protestant Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. Lee Ellis, M. D.

12/24/1929 (Address) 527 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL 12-26-1929

20 UNDERTAKER: Chas I. A. Gibson ADDRESS 1735 Pennsylvania Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

B 52264

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 B 52264

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST. 28-72 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances P. McKinny

(a) RESIDENCE No. 943 E. Pree St Gte Phila ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia McKinny

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor of Music

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Daniel McKinny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila., Pa

12 MAIDEN NAME OF MOTHER Pauline Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Rev. G. V. McKinny C.M. (Address) 3812 Simon Road Balto Md

15 Filed DEC 24 1929 . 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 — 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-17 . 1929 . to 12-28 — 1929.

that I last saw him alive on 12-23 — 1929,

and that death occurred, on the date stated above, at 10 22 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lud T Claudon M. D.

Dec 23 1929 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Germantown Pa.	12-24-29
20 UNDERTAKER Martin Fahay & Sons	ADDRESS 1422 W North Ave.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52265

CERTIFICATE OF DEATH

100-001 E 52265

24-35

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1888 Richardson St. St., Ward)

2-FULL NAME Edward A. Holmstead

(a) RESIDENCE NO. 1888 Richardson St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 19 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 8, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	0	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Martin Holmstead.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Denmark.

12 MAIDEN NAME OF MOTHER Elizabeth Landwehr.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Elizabeth Landwehr. (mother)
(Address) 1888 Richardson st.

15 Filed DEC 24 1929 H. WILSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eenhardt, M. D.

12/23/29 (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar [redacted] Cem

DATE OF BURIAL Dec 24 1929

20 UNDERTAKER Chas. L. Stevens

ADDRESS 120 E Fort Ave

C OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-3-19—H. P. Co.—1000 Bks.

52266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 52266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 W. Cross St.) (WARD) 21-34

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Wing

(a) RESIDENCE. NO. 417 W. Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Wing

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Geo. Wing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant (Address) Annie Wing 417 W. Cross St

15 Filed DEC 24 1929 19 [illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 22 1929 that I last saw h[illegible] alive on Dec 22, 1929 and that death occurred, on the date stated above, at 12:20 A. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Do Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H. Hollis M. D.

Dec. 29 (Address) 7125 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 25 1929

20 UNDERTAKER John H. Joachim and Son

ADDRESS 1027 [illegible]

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lths.

E 52267

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 52267

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 N Wolfe ST. 8-17 WARD)

2—FULL NAME Mrs A Forester

(a) RESIDENCE NO. 1510 N Wolfe ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W.	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble setter

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. H. Forester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary F. Forester
(Address) 1510 N Wolfe st

15 Filed DEC 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21-29

17 I HEREBY CERTIFY, That I attended deceased from 12-1-29 19..., to 12-21 19 29 that I last saw h alive on 12-21-29 and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12-24-29 (Address) 500 N Dallas St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	12/34/1929
20 UNDERTAKER Robt J Turner	ADDRESS 1441 N Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52268

CERTIFICATE OF DEATH

179 ✓ E 52268

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 15-22 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Weston

(a) RESIDENCE NO. 1319 N Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb 6 - 1924

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	5	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Weston

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Jordan.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John Weston
(Address) 1319 N Monroe St

15 Filed DEC 24 1929 H. A. JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd Degree burns
(accident)

(duration) yrs. mos. Fourteen days

CONTRIBUTORY (Secondary) Playing with fire

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquest

(Signed) H. Schmidt, M. D.

Dec 25 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 25 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52269

CERTIFICATE OF DEATH.

11-001

E 52269

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 603 W. Lee St.) (Ward) 11-30

2-FULL NAME Samuel Washington

(a) RESIDENCE NO. 603 W. Lee St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Washington

6 DATE OF BIRTH (month, day, and year) Mar. 10 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Charleston

(State or country) S. C.

PARENTS

10 NAME OF FATHER Jefferson Washington

11 BIRTHPLACE OF FATHER (city or town) Charleston

(State or country) S. C.

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) (?)

14 Informant Sarah E. Washington

(Address) 603 W. Lee St.

15 Filed ..... 19 .....

C 24 1929

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22 19 29

17

I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Dec 22, 1929, that I last saw him alive on Dec 21, 1929, and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(duration) ..... yrs. ..... mos. 3 1 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) D. H. Carver, M. D.

12/23 1929 (Address) 830 Shango St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 12/24 1929

20 UNDERTAKER Samuel H. Smedley ADDRESS 5 N. Eutaw

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52270

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52270

CERTIFICATE OF DEATH

11-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 807 S Paca. (St.) 21-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry D Kleist

(a) RESIDENCE NO. 807 S Paca. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Kleist

6 DATE OF BIRTH (month, day, and year) July 13 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa.

PARENTS

10 NAME OF FATHER John J Kleist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Maria Rodenigas

(Address) 1112 Ridgely St

15 Filed 24 1929 19 H. HOUSTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17

I HEREBY CERTIFY, That I attended deceased from 12/22/29, 19, to 12/23/, 19 29

that I last saw h alive on 12/23/29 5 50 P m. 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

a. Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sheldon Adam M. D.

12/31/29 (Address) 1112 Ridgely St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa

DATE OF BURIAL 12-24 1929

UNDERTAKER Bernard C Harle

ADDRESS 1000 S Paca St

Cor.—10-10-29—A Co.—100 Bks.

Annie Adams

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 ✓

E 52871

CERTIFICATE OF DEATH

REGISTERED NO. E 52871

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Adams

(a) RESIDENCE NO. 1038 Ashland Ave St., Ward

(Usual place of abode) life

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7/1874

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	55	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Dennis Adams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs. B. Elliott (niece)
(Address) 1038 Ashland Ave.

15 Filed DEC 24 1929 JOHN M. JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pelvic Neoplasm
Lymphatic Metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

12/23/1929 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel.

DATE OF BURIAL 12/24 1929

20 UNDERTAKER L. P. Evans Undertaking Co

ADDRESS 20 S. St Paul

Be sure that all items are answered, or that it may be properly examined. Erase statement of cause of death very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52272

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 52272

CERTIFICATE OF DEATH

8-13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1749 Ellsworth Place St.) (Ward)

2-FULL NAME Catherine Grubert

(a) **RESIDENCE NO.** 1749 Ellsworth Place St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Grubert

6 DATE OF BIRTH (month, day, and year) Feb 9/1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	78	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bavaria
(State or country) Germany

PARENTS

10 NAME OF FATHER John Grohman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Zimmerman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Dorothy Willis
(Address) 1300 N. Port St.

15 Filed 2-4 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Dec 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
Terminal Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Gen'l)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Mc Allen, M. D.

2/24/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Dec 24th 1929

20 UNDERTAKER Lee S. Leech

ADDRESS 1723 Park Ave

Or DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001
E 52273

REGISTERED NO. 27-56

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5330 Denmore Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bettie Jones

(a) RESIDENCE NO. 5330 Denmore Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wyatt Jones

6 DATE OF BIRTH (month, day, and year) April 12, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Appertmax Co. Va

PARENTS

10 NAME OF FATHER Wyatt Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nellie Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Fannie Lowe Wilkerson

(Address) 5330 Denmore ave

15 Filed 12 4 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1929, to Dec 24, 1929, that I last saw her alive on Dec 24, 1929 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy and Pneumonia Bronchial with Hypostatic Congestion

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Age & Cerebral Arteriosclerosis (duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Exam

(Signed) H. D. Hall, M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 24, 1929
20 UNDERTAKER	ADDRESS
Mrs Kate R. Williams	2224 Schroeder St.

Spec.—1-12-23—MAT—500 Blks.

52274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102

B 32274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 908 Sterling ST. 10-1 WARD)

2-FULL NAME James Baker

(a) RESIDENCE No. 908 Sterling ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Baker

6 DATE OF BIRTH (month, day, and year) Dec 15 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jas Electric.

9 BIRTHPLACE (city or town) (State or country) Va Middlesex

PARENTS

10 NAME OF FATHER Jas Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middlesex Va

14 Informant Florence Baker

(Address) Daughter

15 Filed 24 192 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/21 19 29

17 I HEREBY CERTIFY, That I attended deceased from Apr-30 19 29 to Dec 21 19 29

that I last saw him alive on Dec 21 19 29

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Medical

(Signed) Jas H Walters M. D.

19 (Address) 1438 St George

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Circle Baptist Church Middlesex Va

DATE OF BURIAL Dec 24 1929

20 UNDERTAKER Mrs J. G. Locke

ADDRESS 1302 Jefferson

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52275

CERTIFICATE OF DEATH

7 1001

E 52275

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 43-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Pierce.

(a) RESIDENCE NO. 832 W. Cross ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1844? - 1849?

7 AGE: Years 80? 85? | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown. 087

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: Esau Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Lucy Ann?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia.

14 Informant: Records (Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 22. 1929.

17 I HEREBY CERTIFY. That I attended deceased from Sept 16, 1929, to Dec 22, 1929, that I last saw her alive on Dec 22, 1929, and that death occurred, on the date stated above, at 1:45 A.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Diabetes Insipidus; hypertension (duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Warren H. McLean, M. D.

Dec 22, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Ct — DATE OF BURIAL: Dec 25 1929

20 UNDERTAKER: A. E. Brown & Son — ADDRESS: 108 N. Monty

Cor.—10-10-29—A Co.—100 Bks.

E 52276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 52276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 728 S. Charles St. St. 7-31 Ward)

2-FULL NAME Robert L. Rice. (C)

(a) **RESIDENCE NO.** 728 S. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced, HUSBAND of Nannie Rice. (C)

6 DATE OF BIRTH (month, day, and year) May 16, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
✓	31	7	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Presser
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Virginia.
(State or country)

PARENTS

10 NAME OF FATHER: Robert L. Rice. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Do not know.

14 Informant: Nannie Rice. (C) wife.
(Address) 728 S. Charles St.

15 Filed DEC 24 1929 [illegible] JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Rupture of an Cortic Oneurism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

12/21 19 29 (Address) 1017 S. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Ct — DATE OF BURIAL: Dec 24 1929

20 UNDERTAKER: V. L. S. Brown & Bro — ADDRESS

Of DEATH in plain terms, so that it may be properly classified. EARLY REPORT OF OCCURRENCE is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks. Charles W Saunders

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52277

CERTIFICATE OF DEATH

92 ✓ E 52277

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 13 N Fulton Ave ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. Saunders

(a) RESIDENCE NO. 13 N Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie B Saunders

6 DATE OF BIRTH (month, day, and year) ? ? 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 06

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Finley Bros Co

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jno W. B. Saunders

(Address) 13 N Fulton Ave

15 Filed DEC 24 1929 Herman Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Dec 22, 1929, that I last saw him alive on Dec 22, 1929 and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis - dilated heart pulmonary edema -

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, hemiplegia.

(duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical studies

(Signed) Harry McCarty, M. D.

Dec 23, 1929 (Address) 87 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Dec 27 1929
20 UNDERTAKER	ADDRESS
J. J. Tucker & Sons	N Fulton Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 52278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-00 E 52278

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 N Castle-4 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Kaptain

(a) RESIDENCE NO. 16 N Castle (Usual place of abode) WARD

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Kaptain

6 DATE OF BIRTH (month, day and year) July 28 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Joseph Kaptain

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary Heimel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Josephine Kaptain (Address) 16 N Castle St

15 Filed DEC 24 1929 19 H. L. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1929, to Dec 22 1929, that I last saw alive on Dec 21 1929, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Endocarditis (duration) yrs. 5 mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What confirmed diagnosis? Examination

(Signed) J E Slades, M. D.

(Address) 1430 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 26 1929

20 UNDERTAKER M. W. E. Dupfel Inc — ADDRESS 37 Lamb St

Spec.—8-16-29—L. F. S.—100 Bks.

E 52279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 52279

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 N. Pegister ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mellisa M. Robinson.

(a) RESIDENCE NO. 1833 - Pegister ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas F. Robinson

6 DATE OF BIRTH (month, day, and year) 8-13-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Thomas H. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Parlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos Mitchell

(Address) 1833 Pegister St

15 Filed 19 Registrar

C 24 1929 Vill

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1928, to Dec 21, 1929, that I last saw h.. alive on Dec 21, 1929 and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows

Arteriosclerosis c Hypertension

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis Deformans (duration) 4 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical

(Signed) Laurence B. Sheldon, M. D.

, 19 (Address) 801 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem.	12/25/29
20 UNDERTAKER	ADDRESS
Geo J Rutt	135 Hanover

Spec.—2-29-28—L. F. S.—500 Blks.

E 52280

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 52280

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 14-20 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Stevenson

(a) RESIDENCE NO. 1303 Fremont ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Stevenson

11 BIRTHPLACE OF FATHER (city or town) Carlisle
(State or country) Penn

12 MAIDEN NAME OF MOTHER Martha Hulbert

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country) Md

14 Informant Martha Stevenson

(Address) 1303 Fremont Ave

DEC 24 1929 FILED J. H. JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22-29

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Dec 22, 1929, that I last saw him alive on Dec 22, 1929 and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Jackson M. D.

12/27 1929 (Address) 610 Allendale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 12/26/1929

UNDERTAKER Geo. H. Holland

ADDRESS 160 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

2319 E 32281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-002 E 32281

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST., 43-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vera Jones

(a) RESIDENCE NO. 2339 Madison Ave ST. — WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/30/29

7 AGE: Years ✓ | Months 4 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va -

12 MAIDEN NAME OF MOTHER: Maud Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records -
(Address)

15 Filed 24 1929, 19 — H. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec-22-29

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 22, 1929, that I last saw her alive on Dec 22, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Retropharyngeal abscess

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis media ?
Syphilis ?

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hospital.

Did an operation precede death? Incision Date of 12-21-29

Was there an autopsy? Yes —?

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

Dec. 23 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [redacted]

DATE OF BURIAL: 12/29/1929

20 UNDERTAKER: Mueller H. Holland

ADDRESS: 1631 Druid Hill

Spec.—1-12-23—M&T—500 Blks.

E 52282 HEALTH DEPARTMENT—CITY OF BALTIMORE 52282

CERTIFICATE OF DEATH.

REGISTERED No. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 920 W. 38th St. (Street) (Ward) 13-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Robert Shearer

(a) RESIDENCE No. 920 W. 38th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 23rd 1929

7 AGE: ✓ Years | Months | Days | If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Kenneth H. Shearer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Hilda P. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Kenneth H. Shearer

(Address)

15 Filed DEC 31 1929 Registrar

C 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23rd 19 29

17

I HEREBY CERTIFY, That I attended deceased from Dec 23rd, 19 29, to Dec 23rd, 19 29,

that I last saw h alive on Dec 23rd, 19 29

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth 6½ Month

Atelectasis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. D. Tillich, M. D.

12/23 19 29 (Address) 310 W. Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: Dec 24 19 29.

20 UNDERTAKER: Thanhauser — ADDRESS: 3615 Chestnut Ave

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52283

CERTIFICATE OF DEATH

101-001 E 52283

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1212 William St. WARD 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Laura Ward

(a) RESIDENCE NO. (Usual place of abode) 1212 William ST., WARD

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15, 1876

7 AGE: Years 53; Months 5; Days 9; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): a. a. Co. Md.

PARENTS

10 NAME OF FATHER: Robert Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Veturia Stallings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Miss Bessie Ward

(Address) 1212 William St.

15 Filed 12 24 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 24. 1929.

17 I HEREBY CERTIFY, That I attended deceased from 12-20-29 19, to 12-24-29, that I last saw her alive on 12-24-29 19, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Tuburnous Pleurisy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris M. D.

12-26-29 (Address) 107 East west St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: Dec. 27 1929

20 UNDERTAKER: Margaret D. Flynn

ADDRESS: 14 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52284

CERTIFICATE OF DEATH

143-003

E 52284

1—PLACE OF DEATH South Balto Gen Hosp — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST. 2433 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer Duckett

(a) RESIDENCE NO. 1039 William ST., ____ WARD
(Usual place of abode)

Length of residence in city or town where death occurred ' yrs. 39 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23. 1901

7 AGE: Years 28 | Months 6 | Days 29 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Co. Md.

PARENTS

10 NAME OF FATHER Franklin Whitney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Co Md.

12 MAIDEN NAME OF MOTHER Ellen Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A.A. Co Md.

14 Informant: Mrs. Ellen Hubert

(Address) 1039 William St

15 2 4 1929, 19 ____ H. MASON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22/29

17

I HEREBY CERTIFY, That I attended deceased from 12-18, 19 29, to 12-22, 19 29

that I last saw h CR alive on 12-22, 19 29

and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 9 mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 1 hr. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-22-29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Frances N Tillis, M. D.

, 19 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem.

DATE OF BURIAL: Dec. 24 1929

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Light

Spec.—2-29-28—L. F. S.—500 Bks.

E 52285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 52285

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. City Hospital ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Timothy Oliver

(a) RESIDENCE NO. 1114 Aisquith St ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work orderly

(b) General nature of industry, business, or establishment in which employed (or employer) — 07

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Banks Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lila Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address)

15 Filed DEC 24 1929 1191 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929, to Dec 22, 1929, that I last saw him alive on Dec 22, 1929, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Autopsy

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) Jesse Gravely, M.D.

, 19 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER D. —

ADDRESS Commissioner Health

DEC 21 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 32286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-01 E 32286

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Parker

(a) RESIDENCE NO. 625 W. Lanvale ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address)

15 Filed 12 24 1929 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19-29

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 19 22, to 12-19, 19 29,

that I last saw h[illegible] alive on 12-19, 19 29

and that death occurred, on the date stated above, at 12:50 a. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Varicose ulcer leg

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Longstein, M. D.

12-20 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS DEC 24 1929

DKH

Spec.—2-29-28—L. F. S.—500 Bks.

E 32287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 32287

31

1—PLACE OF DEATH Baltimore City Hospitals (Path.)

REGISTERED NO. 14-27

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Boone (Margaret Matthews)

(a) RESIDENCE NO. 213 Parrish Alley ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 670

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Reese Matthews

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Robinson

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

14 Informant Hospital Records

(Address) .....

15 Filed DEC 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1929, to Dec. 19, 1929,

that I last saw her alive on Dec. 19, 1929

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thundell M. D.

12-19-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

Commissioner of Health

DEC 24 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 52288

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52288

CERTIFICATE OF DEATH

100 991

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Margaret Beales

(a) RESIDENCE NO. 1417 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Beales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Morgaret Ramsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Frank Beales

(Address) 1417 W Lexington St

15 Filed 2 4 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1929, to Dec. 23, 1929, that I last saw h alive on Dec. 23, 1929 and that death occurred, on the date stated above, at 6:08 p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M D Schneider, M. D.

19 (Address) 7 Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	12/25/ 1929

20 UNDERTAKER John J. Kovar & Son. ADDRESS Gorsuch

Spec.—2-29-28—L. F. S.—500 Blks.

E 52289

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-01 E 52289

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-61

CITY OF BALTIMORE: (No.) 7 (Street) Windsor Court Apts (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucie Poole Henkelman

(a) RESIDENCE NO. Windsor Court Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 26 ds. How long in U. S., if foreign birth 66 yrs. 1 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Wm. Henkelman

6 DATE OF BIRTH (month, day, and year): Oct 27 1863

7 AGE — Years: 66 — Months: 1 — Days: 26 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm L. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co. Maryland

12 MAIDEN NAME OF MOTHER: Sarah Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Mrs Fannie P. Plaine (cousin)

(Address) 829-W-35th St-City.

15 Filed 2 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-23-1929

17 I HEREBY CERTIFY, That I attended deceased from About 3 Years 19 ... to 19 ...

that I last saw h... alive on 12-22 19 29

and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Hs

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Blood

(Signed) Henry Russell, M. D.

12-23 19 29 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec 25 1929

20 UNDERTAKER: Stewart & Company — ADDRESS: Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 52290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 E 52290

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) 2-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Bennett

(a) RESIDENCE NO. 204 S. Durham st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elva Bennett

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon driver 23

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 2 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Dec. 21, 1929, that I last saw h. im alive on Dec. 21, 1929 and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Thrower M. D.

12-21, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 24 1929

20 UNDERTAKER Wendell & Dippel

ADDRESS 3009 Eden st

Spec.—1-12-23—M&T—500 Blks.

E 52291

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52291

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 507 N. Lafayette Ave (ST.) 17-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard N. Evans

(a) RESIDENCE NO. 507 N. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie G. Evans

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Technician o/c

(b) General nature of industry, business, or establishment in which employed (or employer) U. of Md. Dental College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Thomas H. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Alice White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Addie G. Evans wife

(Address) 507 W. Lafayette Ave

15 Filed 1929 (Signed) C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to Dec. 22, 1929

that I last saw h alive on Dec 22, 1929

and that death occurred, on the date stated above, at 1030 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue

(duration) yrs 2 mos 17 ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley, M. D.

Dec 23, 1929 (Address) 1220 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec 26, 1929

20 UNDERTAKER John M. Johnson

ADDRESS 2325 Madison Ave

TION is very important. See instructions on back of certificates.

2

Spec.—2-29-28—L. F. S.—500 Bks.

E 52292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11 4 E 52292

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2805 Silver Hill Ave ST., 24 WARD)

REGISTERED NO. 55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennings Woodson Mariner

(a) RESIDENCE NO. 2805 Silver Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Essie L Mariner

6 DATE OF BIRTH (month, day, and year): Nov 18 1874

7 AGE: Years 55 | Months 1 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): 078

(c) Name of employer: United Ry

9 BIRTHPLACE (city or town) (State or country): Ga

PARENTS

10 NAME OF FATHER: Geo. D Mariner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Melissa East

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga

14 Informant: Essie L Mariner

(Address) 2805 Silver Hill Ave

15 Filed 2 4 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-24-29

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Dec 24, 1929, that I last saw h-m alive on Dec 23, 1929, and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Colitis - duration from history 1 yr. 9 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colitis (duration) 1 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S Dublett, M. D.

Dec 24, 1929 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Locomoke City Md

DATE OF BURIAL: 12/26 1929

20 UNDERTAKER: H. A. Cook

ADDRESS: 1217 E Fayette St

Spec.—8-16-29—L. F. S.—100 Bks.

E 52293

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52293

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 8 W. Hamilton ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Hollingsworth Keene

(a) RESIDENCE NO. 8 W. Hamilton ST., ... WARD .....
(Usual place of abode) life
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) March 25, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	83	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Balto. Co., Md.

PARENTS

10 NAME OF FATHER John Henry Keene

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Dorsey Lawrence

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Wm. Pinkney Craig
(Address) Earl Court Apts.

15 Filed DEC 24 1929 C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan'29, 1929, to Dec 23, 1929, that I last saw h[illegible] alive on 12/23/29, and that death occurred, on the date stated above, at 11.07 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (duration) 3 yrs. mes. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Fehling's

(Signed) Geo H. Hoskins, M. D.

, 19 (Address) 5805 Yorktown

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Dec. 26, 1929

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl.
ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52294

CERTIFICATE OF DEATH.

38 E 52294

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital Ward)

2-FULL NAME Ethel Stewart

(a) RESIDENCE NO. 402 N Dallas St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Stewart

6 DATE OF BIRTH (month, day, and year) Aug 9 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seaford Del

PARENTS

10 NAME OF FATHER Chas Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Evelyn Everett

(Address) 1311 Eager St

15 Filed 2 4 1929, 19 C. HOWARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 22, 1929, that I last saw h alive on Dec 23, 1929, and that death occurred, on the date stated above, at 11 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Syphilis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hemorrhage syphilis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M H Kinney, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Seaford Delaware — DATE OF BURIAL 12/28 1929

20 UNDERTAKER Edwin T Crowley — ADDRESS 578 N Bridge

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52295 E 52295

CERTIFICATE OF DEATH

× 52 ✓

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Dowdy.

(a) RESIDENCE NO. Onancock, Va. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
About 65	Unknown	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. yo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Dan Dowdy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Hatter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed DEC 24 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to Dec 19, 1929, that I last saw h um alive on Dec 19, 1929, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous arthritis

over (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam. Lab.

(Signed) Warren H. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS DEC 24 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 52296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-003 E 52296

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 516 N. Potomac ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Doemling

(a) RESIDENCE NO. 516 N. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Doemling

6 DATE OF BIRTH (month, day, and year) Aug 17/1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Schneider

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER — —

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Mrs Elizabeth Nell

(Address) 516 N. Potomac St

15 FILED DEC 31 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21/29

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1929, to December 21, 1929, that I last saw her alive on December 21, 1929 and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Endarteritis Obliterans

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Right leg and Thigh (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no What test confirmed diagnosis? Physical Examination

(Signed) Albert Abrahms M. D.

12/31 1929 (Address) 2027 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 26 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52297

CERTIFICATE OF DEATH

+ 188-103

E 52297

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Monument A St + Highland Ave St. No 37 Ward)

2-FULL NAME John T. Beaty Jr.

(a) RESIDENCE NO. Marley + Essex Ave St. Balt Co. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5/1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	5	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John T. Beaty Sr.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah E. Magness

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John T. Beaty
(Address) Marlyn + Essex ave

15 Filed DEC 5 1929 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Skull
auto in which he was riding
probably skidded + overturned
ac

(duration) hrs. mos.

CONTRIBUTORY (Secondary) Fract C. C. Humerus L

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Monument + Eaton

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C. J. Clement

(Signed) L. Brann, M. D.

12/24/29 (Address) 3939 E. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Dec 26 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 E 52298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 17-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Smocina

(a) RESIDENCE No. 819 N Collington Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Smocina

6 DATE OF BIRTH (month, day, and year) June 20 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Victor Pretl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Maria Bernak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Anthony Smocina (Address) 819 N Collington Ave

15 Filed 2 5 1929 19 H.H.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-20 1929 to 12-22 1929, that I last saw her alive on 12-22 1929, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Step to coeum Sore Throat

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Step to coeum Septicaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) H. H. Emory M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec 26 1929

20 UNDERTAKER Frank Leach & Son 1906 E Lan

ADDRESS Landover

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52299

CERTIFICATE OF DEATH

31

E 52299

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsbith Batler.

(a) RESIDENCE NO. 134 East ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
18	✓	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Anderson McPherson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Gertrude Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys County.

14 Informant Hospital Record

(Address)

15 Filed 2 5 1929, 19 CHARLES JONES, M. D. Registrar

Per Rill

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 19 29, to Dec 22, 19 29, that I last saw h alive on Dec 22, 19 29, and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (acute)

Indefinite (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy.

(Signed) Jas Chandler M. D.

19 (Address) City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 12-25 1929

20 UNDERTAKER Byron Wright

ADDRESS 218 McElderry St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52300

CERTIFICATE OF DEATH

31

E 52300

REGISTERED NO. 17-55

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5811 Park Heights Ave. ST. 27 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Weintraub

(a) RESIDENCE NO. 5811 Pk. Hgts. Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER William Weintraub

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Moss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Balto. St.

15 Filed DEC 29 1929 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 25-1929

17 I HEREBY CERTIFY, That I attended deceased from 1/5/23, 19, to 12/25/29 19, that I last saw h. alive on 12/25/29, 19 and that death occurred, on the date stated above, at 5 15 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Clinical & Physical Signs

(Signed) James Brosnan, M. D.

19 (Address) 705 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt. Carmel	12-25 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52301

CERTIFICATE OF DEATH

101-001

E 52301

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1014 N. Calhoun St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Giles

(a) RESIDENCE NO. 1014 N. Calhoun St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov 27 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Albert Giles

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown Emma J. Ross

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Emma J. Giles
(Address) 1014 N. Calhoun

15 Filed ..... 19.... J. LOUIS, M. D. Registrar

DEC 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Linke, M. D.

(Address) Dec 24-29 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Dec 26 29
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	403 Mosher

IMPORTANT. See instructions on back of certificate. If DEATH OCCURRED in plain terms, so that it may be properly classified. Exact statement of occupation is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52302

CERTIFICATE OF DEATH.

90 E 52302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6111 Glory Ave (St.) Mt. Washington (Ward) 37

2-FULL NAME Annie L. Palmer

(a) RESIDENCE NO. 6111 Glory Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L. Palmer

6 DATE OF BIRTH (month, day, and year) July 12-1865

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER John Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Earl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George L. Palmer

(Address) 6111 Glory Ave

15 Filed DEC 25 1929

16 C. HUBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/9 1929 to 12/24 1929 that I last saw h[illegible] alive on 12/23 1929 and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal

Myocarditis Vulgaris

(Hernia Congenital Right Side)

(Duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Valvulodenosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry F. Cassedy M. D.

12/24 1929 (Address) Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet-Fredands (Balto Co) DATE OF BURIAL Dec. 26 1929

20 UNDERTAKER Horace H. Burgee ADDRESS 3201 Falls Road

TION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52303

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Saratoga + Green ST. 15-21 WARD)

REGISTERED NO. 161-001 F 52303

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby boy Kirwan (Wesley Kirwan)

(a) RESIDENCE NO. 1522 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Clinton Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Regina Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant Clinton Kirwan

(Address) 1522 N. Monroe St.

15 Filed DEC 26 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 24, 1929

that I last saw him alive on Dec 24, 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Premature infant

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

Dec, 19 29 (Address) Freemont + Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgans Chapel, Woodbine Md

DATE OF BURIAL Dec 26 1929

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-001

E 52304

CERTIFICATE OF DEATH

E 52304

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 250 N. Pine ST. 4-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Johnson

(a) RESIDENCE NO. 250 N Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 10 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 16-1898

7 AGE: Years 31 | Months 10 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bartender

(b) General nature of industry, business, or establishment in which employed (or employer): Other

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Feller Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jennie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sister Williams

(Address): 250 N. Pine St

15 Filed ... 19 ... Registrar

FEB 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Dec 22, 1929, that I last saw him alive on Dec 21, 1929, and that death occurred, on the date stated above, at 7-45 A m.

The CAUSE OF DEATH* was as follows:

Cerebrosis Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. exam.

(Signed) Mark E. Magruder M. D.

12/24/1929 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 12/26/29

20 UNDERTAKER: Samuel D Wemsley

ADDRESS: 718 N Bdle

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52305

CERTIFICATE OF DEATH

129 ✓

E 52305

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 S. Curley ST., 1-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clothilda Canitz

(a) RESIDENCE NO. 601 S. Curley ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Canitz

6 DATE OF BIRTH (month, day, and year) June 7 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Cincinnati (State or country) Ohio

PARENTS

10 NAME OF FATHER Joseph Kenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Charles Canitz

(Address) 601 So. Curley

15 Filed DEC 20 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22/29.

17

I HEREBY CERTIFY, That I attended deceased from 12/15, 1929, to 12/20, 1929, that I last saw her alive on 12/20, 1929 and that death occurred, on the date stated above, at 4 PM a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Duration

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Uremia Duration

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jay A Anderson, M. D.

, 19 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Dec 26 1929

20 UNDERTAKER Louis J Lemann — ADDRESS 32 S Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 5 2306

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5 2306.

CERTIFICATE OF DEATH.

45 V [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) St Joseph's Hospital 28-64 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Schutte

(a) RESIDENCE NO. 4412 Maine Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 7½ yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 / 1874

7 AGE — Years 55 — Months 6 — Days 27 — If LESS than 1 day, hrs. ..... or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis Schutte

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Scheper

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Mrs. Jos. Schutte
(Address) 4412 Maine ave.

15 Filed 2-8-1929, 19 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-22 —, 1929, to 12-23, 1929, that I last saw her alive on 12-23, 1929, and that death occurred, on the date stated above, at 10 25 p.m.

The CAUSE OF DEATH* was as follows:

Rupture of Colon c
Generalized peritonitis

(duration) ..... yrs. ..... mos. several ds.

CONTRIBUTORY (Secondary) Carcinoma Sigmoid & Recto Colon

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of 12-23-29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) W. H. Lundrigan, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem.

DATE OF BURIAL Dec. 27 1929

20 UNDERTAKER Jos. J. Derr

ADDRESS 156 N. Luzerne Ave.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52307 HEALTH DEPARTMENT—CITY OF BALTIMORE E-52307

E 52307 CERTIFICATE OF DEATH [redacted]

1—PLACE OF DEATH 2616 E. Preston St REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Frances Fitzs

(a) RESIDENCE NO. 2616 E. Preston ST., WARD Reisterstown

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Fitzs

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spinster 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co (State or country) Md

PARENTS

10 NAME OF FATHER Hazel P. Cook

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Amanda Shirkdale

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Joshua Fitzs

(Address) Reisterstown Md

15 Filed [illegible] 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Dec 23, 1929, that I last saw h[illegible] alive on Dec 20, 1929 and that death occurred, on the date stated above, at 5-15-P m.

The CAUSE OF DEATH* was as follows:

Cancer of Intestines

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fluid drawn from abdomen at County

(Signed) H. M. Black, M. D.

19 (Address) Reisterstown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL David Ridge Cem. DATE OF BURIAL Dec 26 1929

20 UNDERTAKER Jos. L. Herr ADDRESS 1564 Lafayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52308

E 52308.

CERTIFICATE OF DEATH

188-103

E 52308

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 10-14 Ward)

2-FULL NAME John Friel

(a) RESIDENCE NO. 703 E Biddle St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 31 1865

7 AGE: Years 64 Months 5 Days 21 IF LESS than 1 day ...hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Friel

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Dillon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mary E McIntyre
(Address) 703 E Biddle St

15 Filed ....., 19.. C. HAMPSON JONES, Registrar

Per .....

DEC 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Broncho Pneu — while walking reading was struck by auto

2e (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar L

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bowley's Lane & Pulaski

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Frame M. D.

12/ , 19 9 (Address) 1134 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nat'l

DATE OF BURIAL: 12/27 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 E Fort Ave

IMPORTANT—If plain words are not used, or if any of the items are illegible, or if any important facts are omitted, the certificate may be returned for correction. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52309

CERTIFICATE OF DEATH

12 E 52309

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3506 (Copley Road ST.) 15-6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Friedrich Dorschel

(a) RESIDENCE NO. 3506 Copley Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Dorschel

6 DATE OF BIRTH (month, day, and year): Sept 21 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Meat Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Dorschel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Gertrude Dorschel

(Address) 3506 Copley Rd

15 Filed DEC 26 1929, 19 [illegible] M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22-1929

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1929, to Dec 22, 1929, that I last saw h[illegible] alive on Dec 22, 1929 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Cardiac Dilatation)

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis of Liver (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Wylie & Eutaw Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec 26 1929

20 UNDERTAKER: H. Friedrich Sons

ADDRESS: Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

E 52310 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 52310**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Chelsea Ter ST.) 15-65 (WARD) REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hester Laomia Rees

(a) RESIDENCE NO. 2120 Chelsea Ter ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Frederick Rees

6 DATE OF BIRTH (month, day, and year) March 24 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
53	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Crowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard E. Rees
(Address) 2120 Chelsea Ter

15 Filed DEC 26 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23/29

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1926, to Dec 23, 1929, that I last saw her alive on Dec 22, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestine & Mesentery

(duration) 3 yrs. 8 mos. 28 ds.

CONTRIBUTORY (Secondary) Carcinoma of Intestine & Mesentery (duration) 3 yrs. 8 mos. 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 25-26

Was there an autopsy? No

What test confirmed diagnosis? Examination & Operation

(Signed) G W Bellis, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Dec 1929

20 UNDERTAKER J. Frederick Sons ADDRESS Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52311

CERTIFICATE OF DEATH

E 52311

REGISTERED NO.

1—PLACE OF DEATH May Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 500 N Calvert ST. 4-7 WARD)

2—FULL NAME Sarah Elizabeth Holland

(a) RESIDENCE NO. 126 Winters Ave. Catonsville ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elias Holland

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hester Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elias Holland

(Address) 126 Winters Ave

15 Filed DEC 26 1929 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 19, 1929, to December 23, 1929, that I last saw h[illegible] alive on December 23, 1929 and that death occurred, on the date stated above, at 1.35 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Dec 20, 1929

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Laurence Nesbitt, M. D.

12-23 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ellis. Md.	Dec. 26 1929
20 UNDERTAKER	ADDRESS
Samuel W. Brashears	1400 W Baltimore

Spec.—1-10-21—M&T—1500 Bks.

E 52312

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52312

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Caton & Wilkens Avenues ST. 817 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Brown

(a) RESIDENCE No. 1600 N. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Brown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Martin Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Thomas Brown

(Address) 1600 N. Durham St

15 Filed 2 6 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-10, 1929, to 12-23, 1929, that I last saw h-r alive on 12-28, 1929, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

chronic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Cramer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Patrick's

DATE OF BURIAL 12/26 1929

20 UNDERTAKER J. A. Moran

ADDRESS 2005 E Baltimore

CO TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52313

CERTIFICATE OF DEATH

× 7 | 001 E 52313

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harold Knox

(a) RESIDENCE NO. 1604 Madison Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pa

PARENTS

10 NAME OF FATHER Wm Knox

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Louise Long

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Louise Knox
(Address) 1604 Madison Ave

15 Filed 26 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Dec 23, 1929,

that I last saw him alive on Dec 23, 1929

and that death occurred, on the date stated above, at 6:25 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Pneumococcic)

(duration) yrs. about mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) H. L. Jackson M. D.

12/24/29 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec 26, 1929

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Linden Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52314

CERTIFICATE OF DEATH

111-601

E 52314

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Mulliken ST. 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Aline Stewart

(a) RESIDENCE NO. 1711 Mulliken ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
f	C	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm H Stewart

(Address) 1711 Mulliken

15 Filed DEC 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Dec 22, 1929, that I last saw her alive on Dec 22, 1929, and that death occurred, on the date stated above, at 12 00 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) Geo S Allen, M. D.

12-22-1929 (Address) 508 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec 26, 1929

20 UNDERTAKER Mrs. R.A. Elliott

ADDRESS 1725 Ashland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52315

CERTIFICATE OF DEATH

74-001

REGISTERED NO. E 52316

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 923 N. Carey ST. 16-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Hutchins

(a) RESIDENCE NO. 923 N Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Collie Hutchins

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber, Odd

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Calvert County Maryland

PARENTS

10 NAME OF FATHER: John Hutchins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert County Maryland.

12 MAIDEN NAME OF MOTHER: Collie Laws

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hampton Virginia

14 Informant: Lena Clemons

(Address): 923 N Carey

15 Filed 26 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20th, 1929, to Dec. 22nd, 1929, that I last saw h[illegible] alive on Dec. 2nd, 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen J Brown, M. D.

, 19 (Address) 1009 Mosher St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Dec 26, 1929

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 3224 Schroeder St

Spec.—1-12-23—M&T—500 Blks.

E 52316

E 52316

E 52316.

E 52316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90V

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 W. Saratoga ST.) 16-26 (WARD)

2-FULL NAME Frances Ann Griffin

(a) RESIDENCE NO. 1042 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	col	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Barney Griffin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Snow Hill, (State or country) Md

PARENTS

10 NAME OF FATHER William Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Frances Ella Griffin

(Address) 1042 W. Saratoga St.

15 Filed 1923, 19 Feb 1 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-12-, 1929, to 12-24, 1929.

that I last saw h alive on 12-23-, 1929

and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

Terminal Broncho-pneumonia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Decubitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. L. Jackson, M. D.

12/24 1929 (Address) 620 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec 28, 1929
20 UNDERTAKER	ADDRESS
Mr. Katie R Williams	322 W Lafayette St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52312

CERTIFICATE OF DEATH.

129 E 52312

REGISTERED NO.

1-PLACE OF DEATH Balto and Fayette Sts

City of BALTIMORE: (No. German Aged Home St. 90-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theta G. Roth

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Roth

6 DATE OF BIRTH (month, day, and year): Dec 27 1850

7 AGE: Years 79 | Months 11 | Days 29. | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Conrad McTeele

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Lehman

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant German Aged Home Records

(Address) Balto and Fayette Sts

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23" 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1929, to Dec 23, 1929, that I last saw h[illegible] alive on Dec 21st, 1929, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 1 mos. 12 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Houff, M. D.

12/23 1929 (Address) 1643 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Date of Burial Dec 26" 1929

20 UNDERTAKER: Joseph B Cook ADDRESS 1003 N Eutaw

very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52318

CERTIFICATE OF DEATH

× 49 ✓

E 52318

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chester Hoffman

(a) RESIDENCE NO Hagerstown Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	~~Married~~ Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 27, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Adam Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Fizzie Krier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Adam Hoffman

(Address) Hagerstown, Md

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24-29

17

I HEREBY CERTIFY, That I attended deceased from 11-22, 1929, to 12-24, 1929, that I last saw h alive on 12-24, 1929 and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Squamous cell epithelioma Larynx

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Mediastinal abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

12/24 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown, Md.	Dec 27, 1929
20 UNDERTAKER	ADDRESS
Fred W. Kraiss	Hagerstown, Md

Spec.—8-16-29—L. F. S.—100 Bks.

E 52319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52319

100-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1419 Mc Henry ST., 24 WARD) 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Inabalia J. McKenzie

(a) RESIDENCE NO. 1419 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Mc Kenzie

6 DATE OF BIRTH (month, day, and year) Feb 14 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
73	72	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas E Ridgley

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lillie Thompson

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore

14 Informant Albert Mc Kenzie

(Address) 1419 Mc Henry St

15 Filed 19

C 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22-29

17 I HEREBY CERTIFY, That I attended deceased from 12/9/, 19 29, to 12/22/29, 19, that I last saw h alive on 12/22/29, 19, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) sixty days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Levy, M. D.

12/22/29 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/26 1929

20 UNDERTAKER Robert Brookson — ADDRESS Catherine Mullin

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52320

CERTIFICATE OF DEATH

90 E 52320

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 Prestbury ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah E Billmyer

(a) RESIDENCE NO. 3005 Prestbury ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse F Billmyer

6 DATE OF BIRTH (month, day, and year) Sept 26 52

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo Imbert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Hildebrandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clarence Billmyer

(Address) 3005 Prestbury.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 1929 to Dec 24 1929, that I last saw her alive on Dec 23 1929 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocardial Insuff

Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

2 Years (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? S E.

(Signed) Thomas L Lee, M. D.

1930. 19 29 (Address) 735 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lemmonstown Cemetery

DATE OF BURIAL Dec 26 1929

20 UNDERTAKER W Maurice Poulton

ADDRESS 2238 N Gilmor

Spec.—2-29-28—L. F. S.—500 Blks.

E 52321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94-001

E 52321

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27-447 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME WILLIAM J. BOYLE

(a) RESIDENCE NO. 5403 Tremore Road ST. Hamilton WARD 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) 12/26/1856 Unknown

7 AGE 72 Years | Months 11 | Days 28 | If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address)

15 Filed DEC 29 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 24, 1929, that I last saw him alive on Dec 24, 1929, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

Hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Central Hemorrhage (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam (No autopsy)

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec 27 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 Broadway

52322 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 LE 52322

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3012 Fehnsdale. ST. 27-44 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs. Gertrude E. Trueschler

(a) RESIDENCE. NO. 3012 Pelnsdale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Philip J. Trueschler

6 DATE OF BIRTH (month, day, and year) Aug. 2 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	4	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Cornelius Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Reinebach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Philip J. Trueschler
(Address) 3012 Pelnsdale ave

15 Filed 19 Registrar

C 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to 12/24, 1929, that I last saw h[illegible]live on 12/24, 1929, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Microscopic

(Signed) Hyde W. Kelly, M. D.

, 19 (Address) 5705 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 27 1929
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 N. Broadway

THIS IS very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 52323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hosp St., 27-42 Ward)

2-FULL NAME Frank X Miller

(a) RESIDENCE NO. 5615 Benton Heights Av Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of Anna M. Miller

6 DATE OF BIRTH (month, day, and year) Dec - 12 - 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	0 11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car Repairer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant Anna M Miller
(Address) 5615 Benton Heights Av

15 Filed ....., 19..... Registrar

DEC 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
walked into side of moving auto
ac (duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Fract Ribs
(duration) yrs. 1 mos. ds.

18 Where was disease contracted? If not at place of death? Hospital Clinic
Did an operation preeede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H. L. Frame, M. D.
12/25 1929 (Address) 2939 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Park Wood Cem — DATE OF BURIAL Dec 28 1929

20 UNDERTAKER John Mc[illegible] — ADDRESS 2110 Alon

Be sure the plain words, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 ✓ E 52324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Emerson Hotal St. 15-61 Ward)

2-FULL NAME Gilbert H. Panitz

(a) RESIDENCE NO. 2602 Garrison Blvd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Berman Panitz

6 DATE OF BIRTH (month, day, and year) September 26. 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	39	2	28 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Attorney At Law of ✓
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Simon Panitz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Panitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Mrs Annie Berman Panitz
(Address) 2602 Garrison Blvd

15 Filed ..... 19..... Registrar

C 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
Contributory

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) ..... M. D.
..... 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem — DATE OF BURIAL Dec 26 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Eutaw St

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52325 HEALTH DEPARTMENT—CITY OF BALTIMORE 1001

CERTIFICATE OF DEATH. 101 E 52325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 16-22 WARD)

2-FULL NAME Sarah Silansky

(a) RESIDENCE No. 1232 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Jewish

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Silensky

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 68; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Hyman Fichandler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fanna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E. Baltimore St

Filed DEC 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/25 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/20, 1929, to 12/25, 1929, that I last saw h[er] alive on 12/25, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, rt. lower

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) (1) Pleurisy, rt. Pleura (duration) (2) 20 yrs. mos. (1) 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel J. Hankin, M. D.

12/26 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rest Rem

DATE OF BURIAL: 12/26 1929

UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52326

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52326

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2005 Gratt St. 2-4 Ward)

2-FULL NAME John Stawski

(a) RESIDENCE NO. 2005 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Stawski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	36	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Frank Stawski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mary Stawski
(Address) 2005 E Pratt St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Gun Shot wounds head & chest.
Hemorrhage (Revolver)
(duration) Instant yrs. mos. ds.

CONTRIBUTORY Shock
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H Geadel M. D.

, 19 (Address) 43 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	12/28/1929
20 UNDERTAKER	ADDRESS
Wm Fiaschetti	1618 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52327

CERTIFICATE OF DEATH

14-801 E 52327

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 E. 20 ST. 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Dyer

(a) RESIDENCE NO. 1101 E. 20 st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Dyer

6 DATE OF BIRTH (month, day, and year) Dec 28 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71		11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Whalen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER K. Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Daughter Kelly.

(Address) 1101 E 20 st.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 29 to Dec 24, 19 29 that I last saw h alive on Dec 24, 19 29 and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
Cerebral Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Keith, M. D.

, 19 (Address) 532 E 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Dec 27 1929

20 UNDERTAKER: Geo. J. Keith

ADDRESS: 1735 Harford av

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52328

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

REGISTERED No. E 52328

CITY OF BALTIMORE: (No.) South Baltimore General ST. [illegible] (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mallas

(a) RESIDENCE NO. 1836 Eastern ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Mallas

6 DATE OF BIRTH (month, day, and year) Dec 15, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER John Mallas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Mrs M. Mallas

(Address) 1836 Eastern Ave. Balto. Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25-29

17 I HEREBY CERTIFY, That I attended deceased from 11-21, 1929, to 12-25, 1929

that I last saw h[illegible] alive on 12-25, 1929

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Pulmonary Oedema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/27/29 Right Amputation

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Joseph G. Rauscath, M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	12/27/1929

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hartford Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52329

1-PLACE OF DEATH

CERTIFICATE OF DEATH

61-001

E 52329

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No.) 920 Harlem St., 16-23 Ward

2-FULL NAME Priscilla Waters

(a) RESIDENCE NO. 920 Harlem St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			10	11

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Preston Waters

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Daisy Holmes

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant (Address) Preston Waters 920 Harlem St

96 Filed Dec 26 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Bond Norris, M. D.

Dec 26 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec, 26, 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3227 Schroeder St

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52330

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Eastern Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zofia Brzozowska

(a) RESIDENCE NO. 2125 Eastern Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE: Years 45 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 37

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Roman Welzant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Marcinkawska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Brzozowski

(Address) 2125 Eastern Ave

15 Filed 12 26 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929. to Dec 24, 1929.

that I last saw him alive on Dec 24, 1929.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 26, 1929 (Address) 1 x S o Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary DATE OF BURIAL: Dec. 27 1929

20 UNDERTAKER: John M Weber ADDRESS: 401 S. Chester St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52331 47

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54-002

E 52331

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST. 13-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leigh - Jacqueline

(a) RESIDENCE NO. 33rd & Chestnut ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-22-29

7 AGE	Years	Months	Days 27	If LESS than 1 day, hrs. or min.
		10	~~27~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruby Leigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address)

15 Filed DEC 26 1929, 19 Registrar

4196

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-19-29

17

I HEREBY CERTIFY, That I attended deceased from Nov-13, 1929, to Dec 19, 1929, that I last saw her alive on Dec 19, 1929 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Congenital cardiac defect

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12/19/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) T. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health — ADDRESS

DEC 26 1929

Cor.—10-10-29—A Co.—100 Bks.

Margaret Venable

E 52332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 52332

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 10-14 Ward)

2-FULL NAME Margaret Venable

(a) RESIDENCE NO. 717 Ensor St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 27/29

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
✓	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md,

PARENTS

10 NAME OF FATHER Junius Venable

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Maud Knight

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Maud Knight Venable
(Address) 717 Ensor St

15 Filed ..., 19... C. HARRISON JONES, M. D.
Registrar

DEC 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions-Probably of Gastro-Intestinal origin.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at hopkins hospital

What test confirmed diagnosis?

(Signed) [signature] M. D.

12/20/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec. 24, 1929
20 UNDERTAKER Wm. R. G. Elliott	ADDRESS 1725 Eastlund

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

52333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-001 E 52333

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 17-26 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James V. Davis

(a) RESIDENCE NO. 735 George St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5/1909

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	20	~~0~~ 10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Phila, Pa.

PARENTS

10 NAME OF FATHER Vincent Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Vincent Davis
(Address) Phila., Pa.

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage
Typhoid Fever

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes at Hopkins Hospital

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/20/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cent.

DATE OF BURIAL Dec. 27 1929

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Eastlan...

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52334

CERTIFICATE OF DEATH

129 E 52334

1—PLACE OF DEATH Latrobe Apartments

CITY OF BALTIMORE: (No. Charles & Read ST., 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella O'Neill

(a) RESIDENCE NO. Charles & Read ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) --------

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John O'Neill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Lynch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant S. R. Mears

(Address) 805 N. Calvert Street

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929, to 12/24, 1929, that I last saw h alive on 12/24, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

Chr. hypertrophic heart disease

Chr. Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal pneumonia

Pulmonary edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Examination

(Signed) [illegible], M. D.

12/24 1929 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/27 1929

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 52335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002

E 52335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Patapsco ave ST., 25-9 Aug WARD

2-FULL NAME Martin D. Calvert

(a) RESIDENCE NO. 327 Patapsco ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 21, 1926.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn Md
(State or country)

PARENTS

10 NAME OF FATHER Wm J. Calvert

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Helen Buckstein

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Wm J. Calvert
(Address) Brooklyn Md

15 Filed ..... 19 ..... HARRY JONES, M. D., Registrar

Dec 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1927, to Dec 24, 1929, that I last saw h alive on Dec 24, 1929 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Non Closure of Foramen Ovale

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Explosion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brook M. D.

Dec 24, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Dec 26 1929

20 UNDERTAKER B. Schloman & Son ADDRESS 1039 Fawn St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E. 52336

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52336

CERTIFICATE OF DEATH

44

E 52336

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 834 Hanover ST. 27-3 WARD)

2—FULL NAME John Andrae

(a) RESIDENCE NO. 834 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 24 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

..a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina E. Andrae

6 DATE OF BIRTH (month, day, and year) Dec 31 or 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	63	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Andrae

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Rosina E. Andrae

(Address) 834 Hanover st

15 Filed DEC 28 1929 Cr. H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11. 11. 1929 to 12. 25. 1929 that I last saw him alive on 12. 25. 1929 and that death occurred, on the date stated above, at 2.30a m.

The CAUSE OF DEATH* was as follows: Carcinoma Gastrica with metastasis to the Liver, Mediastinal glands and cervical glands (left) (duration) 2 days Unknown

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 1 ds. 6

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination + X ray examination.

(Signed) Edward Norris M. D.

12.25 1929 (Address) 107 East West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Dec 27 1929
20 UNDERTAKER S. Schulman & Son	ADDRESS 1039 Hanover st

Cor.—10-10-29—A Co.—100 Bks.

52337

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52337

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Hawkins

(a) RESIDENCE NO. 1402 Bhield Al St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Saml.

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Alex Hendy

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Saml. Hawkins
(Address) 1402 Bhield

15 Filed ....., 19.. C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(Apoplexy) (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regulary

(Signed) Dec 24th 1929 H. Leo Hunter, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	12/26 1929
20 UNDERTAKER	ADDRESS
Geo. Geo. H. Holland	1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Last statement of occupation is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 52338

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3000 E. Pratt ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Husted

(a) RESIDENCE NO. 3000 E. Pratt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if foreign birth 85 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Husted

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	81	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Knobel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria K. Weiman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. George Husted (Son)

(Address) 3000 E. Pratt St.

15 Filed DEC 29 1929 C. Hilton Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/1/29, 19..., to 12/24/29, 19 29 that I last saw h er alive on 12/23/29, 19... and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension - Arterio sclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Herrmann M. D.

12/26/29 (Address) 2913 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec. 27. 1929
UNDERTAKER Henry Sander & Sons. Inc.	ADDRESS Baltimore St & Broadway.

Cor.—10-10-29—A Co.—100 Bks.

E 52339

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52339

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No.) St. Joseph's Hospital St. 13-59 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert L. Blum

(a) RESIDENCE NO. 2513 Brookfield Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bertha Blum

6 DATE OF BIRTH (month, day, and year) March 26th. 1861.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	68	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman
(c) Name of employer The Hub.

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Blum

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Adler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Bertha Blum
(Address) 2513 Brookfield Ave.

15 Filed 19 C. HUNTINGTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24th. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/25/29 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	12/27/ 19 29

20 UNDERTAKER David Sondheim ADDRESS 15-20 W. Mt. Royal Ave.

DEC 26 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52340

CERTIFICATE OF DEATH.

161-29 E 52340

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 1-3 WARD)

2-FULL NAME Baby Boy Swinston

(a) RESIDENCE NO. 725 S. Lakewood Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-14-29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
[redacted]		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Swinston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma Rykagews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John Swinston 725 S. Lakewood Av

15 Filed 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-19 . 19 29 . to 12-24 . 19 29 .

that I last saw h alive on 12-24 . 19 29 .

and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Prematurity 6½ mo. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Michael J Gronfield M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Dec 27 1929

DATE OF BURIAL

20 UNDERTAKER A. W. Brazenton

ADDRESS 1730 Eastern

DEC 26 1929 H. A. BOON-JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52341

CERTIFICATE OF DEATH.

90 E 52341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3307 Janey Rd (St.) (Ward)

2-FULL NAME Mrs Elizabeth M. McKibbin.

(a) RESIDENCE. (No.) 3307 Janey Rd. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1852

7 AGE: Years 77 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 68

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: James G McKibbin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mrs Alice Holmes
(Address) Harrisburg Pa

15 Filed . 19 . H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24/29 19

17

I HEREBY CERTIFY, That I attended deceased from Dec 15/29, 19, to Dec 24/29, 19,

that I last saw he alive on Dec 24/29, 19,

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Jones M. D.

. 19 (Address) 3912 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brookview Lawn — DATE OF BURIAL: Dec 27 19 9

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Hollins

TION is very important. See instructions on back of certificate.

DEC 26 1929

Spec.—2-29-28—L. F. S.—500 Bks.

Mary Tunski

E 52342

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52342

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 46

CITY OF BALTIMORE: (No. Baltimore City St. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Tunski

(a) RESIDENCE NO. 625 S. Wolfe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Unknown

5a If married, widowed, or divorced
~~HUSBAND of~~ WIFE of John Tunski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Tuwa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record
(Address)

15 Filed DEC 29 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17 I HEREBY CERTIFY, That I attended deceased from 12-14, 1929, to 12-23, 1929, that I last saw h.. alive on 12-23, 1929 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Crumpton, M. D.

12-29, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	Dec. 28 1929
20 UNDERTAKER	ADDRESS
George A. Weber	705 S Ann St

Spec.—2-29-28—L. F. S.—500 Bks.

Hartel

E 52343 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48 E 52343

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Reed St. 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliz Hartel

(a) RESIDENCE NO. 304 Reed Ln ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE: 83 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Chas Klingler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cath Meiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Carrie Forst

(Address) 2305 Hanlord Rd

15 Filed ....., 19.... [illegible] JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25/27

17 I HEREBY CERTIFY, That I attended deceased from June, 19 27, to Dec 25, 19 27

that I last saw h[illegible] alive on Dec 25, 19 27

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face hand

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo Reed Dorn, M. D.

Dec 29, 19 27 (Address) 42 700 N Broadway Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Dec 27 1927

20 UNDERTAKER: John J Fields, 2018 Druid Hill — ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52344

CERTIFICATE OF DEATH

1928 E 52344

1-PLACE OF DEATH

REGISTERED NO.

City of Baltimore: (No. 207 W. Montgomery St. St., 22-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Jones.(C)

(a) RESIDENCE NO. 207 W. Montgomery St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ——mos.——ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Peter Jones.(C)

6 DATE OF BIRTH (month, day, and year) October 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	38	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Peter Jones.(C) husband.
(Address) 206 W. Montgomery St.

15 Filed ..... 19..... Registrar

51929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 21, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Stab wound of the heart. (Pocket knife)
Homicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) [illegible] M. D.

12/26 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion CT	Dec 27 1929
20 UNDERTAKER S. W. Broome & Son	ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

52345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

B 52345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Ashland ave ST. 10-14 WARD)

2-FULL NAME Baby Keyes

(a) RESIDENCE No. 1312 Ashland ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 min ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-23-29.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.
✓	—	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER Irvin Keyes

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Lucille Williams

13 BIRTHPLACE OF MOTHER (city or town) Ga (State or country)

14 Informant Mother (Address) 1312 Ashland ave

15 Filed Dec 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1929.

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Dec 23, 1929, that I last saw him alive on Dec 23 1929, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Calvin B. LeCompte M. D.

, 19 (Address) 1113 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 26 1929

Registrar of Vital Statistics

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 52346 ✓ E 52346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 52346 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1512 E. 33rd St. 46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Smith

(a) Residence No. 1512 E. 33rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single,~~ Married, Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Saml F. Smith

6-DATE OF BIRTH (month, day and year) Feb. 14-1851

7-AGE. 78 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer). at home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Alexander Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Nancy Henkel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-

(Informant) Harry Hahn

(Address) 1512 E. 33rd st

15-

Filed..... E. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12. 24. 1929

17- I HEREBY CERTIFY, That I attended deceased from August 1st 1929 to Dec 24 1929

that I last saw h.. alive on Dec. 24 1929

and that death occurred, on the date stated above, at 12 M. noon

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert S. Kirk M. D.

12/25. 1929 (Address) 3126 Hartsdale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Calvert — DATE OF BURIAL, Dec 27th 1929

20-UNDERTAKER. Fred A Hausman — ADDRESS 703 S. Howard

Instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52347

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 06-37 ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Brown

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	(About 70) Unknown			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed DEC 26 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24-29

17 I HEREBY CERTIFY, That I attended deceased from 11-19-29, 19..., to 12-24-29, 19..., that I last saw h... alive on 12-24-29, 19... and that death occurred, on the date stated above, at 3:45 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Acute

Confusion (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 26 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52348 100-001 E 52348

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 76-27 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Hayes

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or diverced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	25		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) odo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thomas Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed DEC 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22-29

17

I HEREBY CERTIFY, That I attended deceased from 5-25-27, 19..., to 12-22-29, 19...

that I last saw him alive on 12-22-29, 19...

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans (Post-encephalitic)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death? 1. at Home 2. In Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy exam.

(Signed) Marvin M. Duff Dean, M. D.

Dec 24. 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 26 1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52349

CERTIFICATE OF DEATH

129 E 52349

1-PLACE OF DEATH Maryland General Hospital

City of BALTIMORE: (No.) (St.) (Ward) 30-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Countess

(a) RESIDENCE NO. 2119 W Mulberry St. Ward

STATE (Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 21 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 2, 1879

7 AGE — Years: 50 — Months: 0 — Days: 23

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City, Md (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Werner

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Hospital Records) (Address)

DEC 26 1929

15 H. HANSON JONES, M. D. Registrar

ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 23, 1929, to December 25, 1929, that I last saw her alive on December 25, 1929, and that death occurred, on the date stated above, at 10 50 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (apoplexy)

Hypertension

Chronic Nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute pulmonary edema

(duration) yrs. mos. 1+ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) John A. Armstrong M. D.

(Address) 1 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: Dec 28 1929

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52350

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52350

CERTIFICATE OF DEATH

43

REGISTERED NO. 5336

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Annapolis Rd ST., 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Henry Meeks

(a) RESIDENCE NO. 2319 Annapolis Rd ST., 25th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Lonnie B. Meeks.

6 DATE OF BIRTH (month, day, and year) Aug 27, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	64	3	23 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glassblower 86

(b) General nature of industry, business, or establishment in which employed (or employer) Not employed

(c) Name of employer for 1 year

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Meeks

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Elyza Wilson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Geo. W. Meeks.
(Address) 2707 Mansel St

15 Filed ..... 19 ..... C. HAMPSON JONES, JR. Registrar

DEC 26 1929 2008

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 24, 1929

that I last saw him alive on Dec 23, 1929

and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Treated by Howard A Kelly.

Was there an autopsy? No

What test confirmed diagnosis? section.

(Signed) Thomas A Meeks M. D.

Dec 24 1929 (Address) 2410 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakin Park	Dec 27 1929
20 UNDERTAKER Harry S. Witzke 4101	ADDRESS Edmondson Av

Spec.—8-16-29—L. F. S.—100 Bks.

E 52351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 52351

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST. 14-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Lamkin

(a) RESIDENCE NO. 101 S. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1889

7 AGE	Years	Months 3	Days	If LESS than 1 day, hrs. or min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Lamkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eleanor Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Hosp. Records

(Address)

15 Filed 2 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24-29

17

I HEREBY CERTIFY, That I attended deceased from 12-21, 1929, to 12-24, 1929, that I last saw her alive on 12-24, 1929 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Ye Date of 12/22/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) J Leyko, M. D.

12/24 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Dec 27 1929

20 UNDERTAKER Harry N. Weitzle, 413 Edmondson Ave

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52352

CERTIFICATE OF DEATH.

118 E 52352

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bram

(a) RESIDENCE NO. 1614 E. 30th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter L. Bram

6 DATE OF BIRTH (month, day, and year) May 10-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry L. Riepner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Linderman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Herbert Murray

(Address) 1614 E. 30th St.

15 DEC 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 24 . 1929 . to Dec 25 . 1929.

that I last saw her alive on Dec 20 . 1929

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Cancerous Bowel)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec. 24-29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. Barranco Per A. Stahl M. D.

. 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Dec. 28 1929

20 UNDERTAKER Wm. C. Black

ADDRESS 927 N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52353

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3036 E Monument ST. 16-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis J Harrison

(a) RESIDENCE NO. 619 N. East ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Harrison

6 DATE OF BIRTH (month, day, and year) Jan 21st 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) O & S

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER David Harrison

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Eva Beckman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Mary J. Harrison

(Address) 619 N. East ave

15 Filed 2 6 1929, 19 Per

G. THOMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov-25, 1929, to Dec-25, 1929, that I last saw him alive on Dec-19-, 1929 and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes -

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) E. Gill Hall, M. D.

Dec 26 1929 (Address) 1631 E North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bridgeton Bridgeton N.J.	Dec 28th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1826 E Monument St

Spec.—1-10-21—M&T—1500 Bks.

E 52354

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 25-26 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael O'Brien

(a) RESIDENCE No. Mt. St. Marys College Emmitsburg Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary T. O'Brien

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 47; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: John O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Bridget McCarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Michael O'Brien St Marys College

26 1929

C. HARRISON, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-26-1929

17

I HEREBY CERTIFY, That I attended deceased from 12-19-1929 to 12-26-1929.

that I last saw him alive on 12-26-1929

and that death occurred, on the date stated above, at 12 45 a m.

The CAUSE OF DEATH* was as follows:

carcinoma of head of pancreas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-19-29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George Brune M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa

DATE OF BURIAL: 12/26/ 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52355

CERTIFICATE OF DEATH

90 E 52355

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1019 N. Edwards ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Goldsborough Burwell

(a) RESIDENCE NO. 1219 N. Bluefield ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE: Years 78 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nathaniel Burwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dorothy Collin Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Burwell

(Address) 1219 N. Belvedere

15 Filed 12 26 1929 G. HAMPSON JONES, M.D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26. 29

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Dec 26, 1929, that I last saw her alive on Dec. 26, 1929 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis - myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lee, M. D.

12 26 1929 (Address) Temple Garden Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va | DATE OF BURIAL 12/28/1929

20 UNDERTAKER John J. Dalton & Sons | ADDRESS 1318 Eighth St. N.W.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52356 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 129 E 52356

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2705 E Fayette St (40 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Scheiner

(a) RESIDENCE NO. 2705 E Fayette St WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Scheiner

6 DATE OF BIRTH (month, day, and year) June 2 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Scheiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Scheiner (Address) 2705 E Fayette St

15 Filed 12 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1929 to Dec 24 1929, that I last saw h... alive on Dec 24 1929, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Nephritis

Arteriosclerosis

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Edema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 1 E Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Dec 27 1929

20 UNDERTAKER M. W. & Deppe — ADDRESS 37 Lan[illegible]

Spec.—2-29-28—L. P. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52357

CERTIFICATE OF DEATH

34 V E 52357

REGISTERED NO. 13-57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 Powers St. ST. WARD

2—FULL NAME George T. Gardner

(a) RESIDENCE NO. 816 Powers St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30, 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER George W Gardner

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER A. Caltrider.

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant George W. Gardner.
(Address) 816 Powers St.

15 Filed 2 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1929, to Dec. 26, 1929, that I last saw h... alive on Dec. 25, 1929 and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows:

1. Pulmonary Edema
2. Cardiac Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Kidney

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Frank H. Martin, M. D.

, 19 (Address) 7011 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 28 1929

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Eastern Ave.

Cor.—10-10-29—A Co.—100 Blks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52358

CERTIFICATE OF DEATH

3-4 197

E 52358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., Ward)

2-FULL NAME Edward Adams

(a) RESIDENCE NO. 244 S. Bethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: ~~white~~ black

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Izetta Adams

6 DATE OF BIRTH (month, day, and year): July 18/1891

7 AGE: Years 38 | Months 05 | Days 5 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): ~~On Ship~~ 021
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Cuba

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Cuba

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Chba

14 Informant: Izetta Adams (wife)
(Address): 244 S.Bethel St

15 Filed ....., 19.... C. HAMPSON JONES, M. Registrar

DEC 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to gunshot wound of thorax, lung, stomach & spleen

Homicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/26/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [redacted] Cem

DATE OF BURIAL: Dec 28, 1929

20 UNDERTAKER: Wendell J Lippert

ADDRESS: 3040 Eden

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52359

CERTIFICATE OF DEATH

100-001.

E 52359

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 1-1 Ward)

2-FULL NAME Pete Koprowski

(a) RESIDENCE NO. 1007 S. Robinson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20/1892

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	37	9	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) German Poland

PARENTS

10 NAME OF FATHER Frank Koprowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) German Poland

12 MAIDEN NAME OF MOTHER Anna Supski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) German Poland

14 Informant Andrew Phillips (cousin)
(Address) 1007 S. Robinson St.

15 Filed 12 26 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to h.i.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Bronchopneumonia (Bilateral)

Unresolved Pneumonia Rt. Upper

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis

(Signed) Jos H Baer, M. D.

12/26/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Upper Rd

DATE OF BURIAL Dec 27 1929

20 UNDERTAKER Wendell J Kipp

ADDRESS 300 E Cden

Cor.—10-10-29—A Co.—100 Bks.

Dr Porter

HEALTH DEPARTMENT—CITY OF BALTIMORE

52360

CERTIFICATE OF DEATH

90 E 52360

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2820 Simpson St. St., 9-46 Ward)

2-FULL NAME Louis Hieronimus

(a) RESIDENCE NO. 2820 Simpson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Hieronimus

6 DATE OF BIRTH (month, day, and year) Oct 17, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	74	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Louis Hieronimus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Robert F. Hieronimus
(Address) 813 E. 30th St.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
(Probable Senile)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Porter, M. D.

12/26/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 12/28/1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul St

DEC 27 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Zellers 2739 Eastern Ave

E 52361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 ✓

E 52361

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 22-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James W Sherman

(a) RESIDENCE NO. 4138 Parkside Drive WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace B Sherman

6 DATE OF BIRTH (month, day, and year): Jan 18, 1853

7 AGE — Years: 76 | Months: 11 | Days: 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): P. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Camden N J

PARENTS

10 NAME OF FATHER: James Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Fred J Wilkinson

(Address) 4138 Parkside Drive

15 Filed 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/25/29

17 I HEREBY CERTIFY, That I attended deceased from 12/11 1929 to 12/25 1929 that I last saw him alive on 12/25 1929 and that death occurred, on the date stated above, at 4:05 P. m.

The CAUSE OF DEATH* was as follows:

Fractured Left Femur (Fell on floor at home.)

Chronic Nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Luther E. Little, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	12/28 1929
20 UNDERTAKER	ADDRESS
H. Cook	1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52362

CERTIFICATE OF DEATH

44 ✓

E 52362

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 27-42 WARD)

2—FULL NAME George W. Callenberg.

(a) RESIDENCE NO. 1128 Hamilton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Catherine E. Callenberg.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Theo Callenberg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Hettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records.

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..., 19... [illegible] JONES, Registrar

C 7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 19 29, to Dec. 24, 19 29, that I last saw h[illegible] alive on Dec. 24, 19 29 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray; clinical exam. Lab.

(Signed) Warren H. McLean, M. D.

Dec 25, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	12/27 19 29
20 UNDERTAKER Wm Cook	ADDRESS 1247 W. Saratoga St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Leibner, 4900 Belair Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52363

CERTIFICATE OF DEATH

12 ✓ E 52363

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1132 Greenmount Ave ST., 10 - 15 WARD)

2—FULL NAME Francis I. Berry

(a) RESIDENCE NO. 1132 Greenmount Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Berry

6 DATE OF BIRTH (month, day, and year) June 8. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) R.R. 078

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William L. Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Turnbull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sallie Berry

(Address) 1132 Greenmount Ave

15 Filed Dec 27 1929 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th 1929, to Dec 24th 1929, that I last saw him alive on Dec 24th 1929, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia 1

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. St Clair M. D.

12 26 1929 (Address) 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	12/27 1929

20 UNDERTAKER William Cook

ADDRESS 1217 E. Lombard St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52364

CERTIFICATE OF DEATH

100-001

E 52364

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 22-30 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. Roder

(a) RESIDENCE NO. Camden & Paca (Hoffman House) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John A. Roder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hosp.

15 Filed DEC 27 1929 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25-29

17 I HEREBY CERTIFY, That I attended deceased from 9-17-29, 19..., to 12-25-29, 19..., that I last saw him alive on 12-25-29, 19..., and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Dementia Praecox

(duration) unknown. yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? 1. Home 2. in Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Marvin M. McKean, M. D.

Dec 26, 1929. (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetary	12/28/ 1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

Spec.–7-17-26—A Co.—200 Bks.

52365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 v E 52365

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 364) Caroline St. 5-9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hymen Albritten

(a) RESIDENCE NO. 364 N. Caroline St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 28 / 1907

7 AGE: Years 22 Months 6 Days 4

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer in Oakum Plant

(b) General nature of industry, business, or establishment in which employed (or employer): Oakum Plant

(c) Name of employer: Grifton, N. Carolina 040

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Nathan Albritten

11 BIRTHPLACE OF FATHER (City or town) (State or country): Greenville N. Carolina

12 MAIDEN NAME OF MOTHER: Celia Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Grifton N. Carolina

14 Informant: Celia Albritten

(Address) 362 N. Caroline St

15 Filed DEC 27 1929

16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 / 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 19 29, to Dec 24, 19 29, that I last saw h~~im~~ alive on Dec 23 / 19 29 and that death occurred, on the date stated above, at 9-05 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard H Eadington M. D.

19 (Address) 1574 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

Date of Burial: Dec 29 1929

20 UNDERTAKER: Edward Bryan

ADDRESS 681 Orleans St

C

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E-52366.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52360

CERTIFICATE OF DEATH.

90 V

E 52360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Frederick Ave. ST. 90-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Hoffman

(a) RESIDENCE No. 2013 Frederick Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank E. Hoffman

6 DATE OF BIRTH (month, day, and year) Oct. 17th. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Schefer

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Kate Eisenbaugh

13 BIRTHPLACE OF MOTHER (city or town) York (State or country) Pa.

14 Informant Frank E. Hoffman

(Address) 2013 Frederick Ave.

15 Filed DEC 27 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 — 1929, to Dec 24 — 1929, that I last saw h[illegible] alive on Dec 23-1 1929, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: —

Pyelitis, Pyelo Nephritis, Myocarditis

(duration) yrs. 2 mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 30-29

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Pathological

(Signed) Estelle Henning, M. D.

12/26, 1929 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec. 27, 1929

20 UNDERTAKER George L. Schwab — ADDRESS 2101 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. DESCRIPTION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52367.

CERTIFICATE OF DEATH

90 E 52367.

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 814 N. 36 ST. 13-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Clinton Kailer

(a) RESIDENCE NO. 814 N. 36 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 7 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Charles B Kailer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Ingerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Kailer

(Address) 814 N. 36 St

15 Filed DEC 27 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 19 29, to Dec. 26, 19 29

that I last saw h[illegible] alive on Dec. 25, 19 29

and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. F. Cullingsworth M. D.

12/28 19 29 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 28 19 29
20 UNDERTAKER	ADDRESS
A. S. Marshall	353 Gallard

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52368

CERTIFICATE OF DEATH

E 52368
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 4-30 St., Ward)

2-FULL NAME Baby Brooks

(a) RESIDENCE NO. Carr Road - Green Spring Valley St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Freeman Brooks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lottie F. Epps

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Lottie Brooks
(Address) Carr Rd. Md

15 Filed Dec 27, 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Hemorrhage from umbilical Cord.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

12/28 1929 (Address) 729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Dec 27 1929
20 UNDERTAKER Samuel Hemsley	ADDRESS 1420 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52369

CERTIFICATE OF DEATH

57 E 52369

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St., 14-21 (Ward)

2-FULL NAME Eliza Jr. Thompson

(a) RESIDENCE NO. 1734 McCulloh St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1873

7 AGE — Years: 56 | Months: 6 | Days: | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER: Geo. Collins

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Lenilla Boardley

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Louis Thompson
(Address) 4300 Lowry Ave

15 Filed DEC 27 1929 C. HOWARD JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regulay

(Signed) Fred Smith, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 27 1929
20 UNDERTAKER: Samuel S. Kemsley	ADDRESS 578 N. Gilmor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52345 E 52370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 52370

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isadore Fagan

(a) RESIDENCE NO. 1421 E Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bennie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Molly Chanbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Dec 26, 1929, that I last saw him alive on Dec 26, 1929 and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach
with metastases to peritoneum
& liver

2 3 (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Ca cells in ascitic Fluid. Autopsy

(Signed) Hedwig Kaemi, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12/27 1929

20 UNDERTAKER Jack Levin ADDRESS 1439 E Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52371

CERTIFICATE OF DEATH

38 DE 52371 1929

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. (WARD) 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J Davenport

(a) RESIDENCE NO. 1100 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Colred

5 Single, Married, Widowed, or Divorced. (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Davenport

6 DATE OF BIRTH (month, day, and year): Unknown 1880

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Minnie Davenport

(Address): 100 Whitelock

15 Filed DEC 27 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 25, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13. 1929 to Dec 25 1929

that I last saw him alive on Dec 25 1929

and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Aneurysm of ascending aorta

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Asphixiation due to pressure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) W. H. Varney, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 12/27 1929

20 UNDERTAKER: Mrs. Geo. A. Holland

ADDRESS: 163 Druid Hill

Spec.—1-12-23—M&T—500 Bks.

E 52372 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52372

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2850 Woodbrook Ave (STREET OR AVENUE) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Ethel Price

(a) RESIDENCE NO. 2850 Woodbrook Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Sales lady

(c) Name of employer Dept store.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Edward Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie R. Leaf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Carrol B. Price (Address) 2850 Woodbrook Ave

15 Filed DEC 27 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 25, 1929, that I last saw her alive on Dec 24, 1929, and that death occurred, on the date stated above, at 2-10 A m.

The CAUSE OF DEATH* was as follows:

Acute Toxemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Lemmon M.D.

12/26/29 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Church Cemetery	Dec 27 1929
20 UNDERTAKER	ADDRESS
Josiah Lyser	1600 N. Wolfe ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52373

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Elmer Bradley St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1240 Lamont

(a) RESIDENCE NO. 1240 Lamont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced was HUSBAND of (or) WIFE of Adelia Bradley

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffeur

(c) Name of employer Consolidated Coal Co

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Austin Bradley

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Lizzie Jones

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Adelia Bradley

(Address) 1240 Lamont

15 Filed 1929 C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 1929, to Dec 27 1929,

that I last saw alive on Dec 24th 1929,

and that death occurred, on the date stated above, at 8 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration 3 yrs 0 mos 27 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Cole, M. D.

12/30/29, 1929 (Address) 52 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 29th 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Pressman

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 52374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 52374

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1743 Ashland ST., 713 WARD)

2—FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 1743 Ashland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Brown

6 DATE OF BIRTH (month, day, and year) May 25, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) King William Co. Va.

PARENTS

10 NAME OF FATHER Wm. Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) King Wm Co Va.

12 MAIDEN NAME OF MOTHER Sarah Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lexington N.C.

14 Informant Margaret Harrison
(Address) 1743 Ashland

15 Filed DEC 27 1929 19 C. P. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17 I HEREBY CERTIFY, That I attended deceased from 12-23-29, 19..., to 12-23, 19..., that I last saw her alive on 12-23, 19 29 and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion, Acute Dilatation of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 27, 1929
20 UNDERTAKER Wm. R. A. Elliott	ADDRESS 1205 Ashland Ave

Important: See instructions on back of certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52375 177 ✓ E 52375

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Charles E Ellis 8-17

City of Baltimore: (No. 1529 N. Broadway St.) Ward)

2-FULL NAME Charles E. Ellis

(a) RESIDENCE NO. 1529 N. Broadway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lete Mary Ellis

6 DATE OF BIRTH (month, day, and year) Feb 24/1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) 51 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Mary Ellis (Daughter)
(Address) 1529 N. Broadway

15 Filed 1929 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Acute Gastritis due to accidental Phosphorus (slight) poisoning Dec 21 (not Para.) & injudicous eating on Dec 22/29

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/27/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	12/27/29
20 UNDERTAKER J. J. Moran	ADDRESS 1306 E Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 52376

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST., WARD) 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Williams

(a) RESIDENCE NO. Reisterstown, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer Wabash Railways

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER George Dodd

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Esther Barkerjust

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Hospital Records

(Address)

15 Filed DEC 27 1929 H. A. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1929.

17

I HEREBY CERTIFY, That I attended deceased from December 26, 19 29 to December 27, 19 29, that I last saw h alive on Dec 27 19 29 19 and that death occurred, on the date stated above, at 2 P m. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to Liver + Brain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Feuer, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bluefry Hollow Cemetery	Dec 29 1929
UNDERTAKER New York	ADDRESS
J. F. Ehrin	Reisterstown Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52377

CERTIFICATE OF DEATH 7H-001

E 52377

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
Pronounced
City of Baltimore: (No. St. Agnes Hospital 16-67 St., Ward)

2-FULL NAME Elias Matthews

(a) RESIDENCE NO. 3135 Baker St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31/1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	64	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sewer Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) City of Balto
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co, Md
(State or country)

PARENTS

10 NAME OF FATHER Aquilla Matthews

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Dent

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Walter Matthews
(Address) 3135 Baker St

15 FILED 27 1929 H. H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Chas. B. Brooke M. D.
Dec 26 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gunpowder, Balto Co	Dec 1929
20 UNDERTAKER Chas E Franck	ADDRESS 802 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52378

E 52378

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1204 W Fontard ST., 18-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. McKewen.

(a) RESIDENCE NO. 1204 W Fontard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49.	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Bartlett Hayward Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John E McKewen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice E Buckey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John McKewen.

(Address) 1204 W Fontard St.

15 Filed DEC 27 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1. 1929. to Dec. 26. 1929.

that I last saw h— alive on Dec. 26. 1929.

and that death occurred, on the date stated above, at 1A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam Etc.

(Signed) Thos Horton, M. D.

12/27 19 (Address) 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 28th 1929
20 UNDERTAKER	ADDRESS
John J Cowan & Son.	90 Holliday

Spec.—2-29-28—L. F. S.—500 Bks.

E 52379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 52379

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto City Hosp. ST., 12-26 (WARD)

2—FULL NAME John Jackson

(a) RESIDENCE NO. 745 George St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor.

(b) General nature of industry, business, or establishment in which employed (or employer) — $0

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Thomas Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 Filed 1929 C. HAROLD JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Dec 22, 1929, that I last saw him alive on Dec 22, 1929, and that death occurred, on the date stated above, at 4:50 a. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis.

Indefinite (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) —

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical & Laboratory.

(Signed) Jas. G. Arnold, M.D.

, 19 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec. 27 1929
20 UNDERTAKER Hatie R. Williams	ADDRESS 922 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 52380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52380

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N. Haven ST. 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Hartzell

(a) RESIDENCE NO. 138 N. Haven ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Hartzell

6 DATE OF BIRTH (month, day, and year): Feb 23/66

7 AGE: Years 63 | Months 10 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Ed. W. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs E. Hartzell

(Address) 138 N. Haven St

15 Filed DEC 27 1929 HAMPSON JONES, M. D. Registrar

C 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26/29

17 I HEREBY CERTIFY, That I attended deceased from 12/24/29 to 12/26/29, 19..

that I last saw her alive on 12/26/29

and that death occurred, on the date stated above, at 12.0 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Enlarged Prostate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hugh A Eagles, M. D.

12/26, 19 29 (Address) 332 36 Gaith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 12/28/29

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

KOPP

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 52381 E 52381

CERTIFICATE OF DEATH

T/H-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 26-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katie Kopp

(a) RESIDENCE NO. 3115 Shannon Drive ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22/1873

7 AGE — Years: 56 | Months: 8 | Days: 5 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jno. Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. David A. Shaughnessy

(Address) 3115 Shannon Drive

15 Filed DEC 27 1929 H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1929.

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929. to Dec 27, 1929.

that I last saw h alive on Dec 26, 1929

and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hypo. Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Spinal puncture & blood

(Signed) W. H. Varnity M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

UNDERTAKER: Philip Herwig

DATE OF BURIAL: Dec 30 1929

ADDRESS 2016 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

E 52382

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52382

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital St.; 12-50 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Hitesheu

(Residence in Baltimore: No. 2520 Green Mount St.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 26 (Day), 1852 (Year)

7-AGE, 77 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles Devilbiss

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther H H

(Address) 2520 Green Mount

15-

Filed DEC 29 1929 for C. HARVEY JONES, M. D. Registrar.

C Z 71929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 26 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 — 1929, to Dec. 26 1929, that I saw her alive on Dec. 26 1929, and that death occurred, on the date stated above, at 12. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Moore M. D.

Dec. 26 1929 (Address) 5600 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Govans Cem Co Timonium Md

DATE OF BURIAL. Dec. 28, 1929

20-UNDERTAKER H M Rouston

ADDRESS 2238 N Monroe

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Bks.

E 52383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 52383

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16-17 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Covington

(a) RESIDENCE NO. 1425 Mosher ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred? 24 yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ora Covington

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER John Covington

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Hattie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed DEC 27 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17 I HEREBY CERTIFY, That I attended deceased from 12-11-29, 19, to 12-23-29, 19, that I last saw him alive on 12-23-29, 19, and that death occurred, on the date stated above, at 1 P.M. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency.

More than 2 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam. Wassermann

(Signed) Marvin M. McLean, M. D.

Balto. City Hosp.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Dec 28, 29

20 UNDERTAKER Sam'l N. Chase Sons ADDRESS 1400 Mosher

Cor.—10-10-28—A Co.—100 Bks.

E 52384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 52384

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 19-16 Ward)

2-FULL NAME Glendora Scott

(a) RESIDENCE NO. 219 N. Carlton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 42 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Jane Alston
(Address) 1316 N. Bruce

15 Filed DEC 27 1928 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20th 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hypertension (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) T. F. Kemp, M. D.
Dec 26 1928 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dist Auburn Cem

DATE OF BURIAL: 12-27-28

20 UNDERTAKER: David Easton

ADDRESS 916 Lanvale

Spec.—2-29-28—L. F. S.—500 Bks.

E 52385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 52385

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 1724 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Foster Winnecott

(a) RESIDENCE NO. 574 Munson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	72 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of Baltimore City Hosp.
(Address)

15 Filed 2 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25-29

17 I HEREBY CERTIFY, That I attended deceased from 11-22-29, 19..., to 12-25-29, 19..., that I last saw him alive on 12-25-29, 19..., and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) more than 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Marvin M. McLean, M. D.

Dec 26, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-29 1929
20 UNDERTAKER	ADDRESS 916 Pa ave
Dennis T. Foster	

Spec.—2-29-28—L. F. S.—500 Bks.

E 52386

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52386

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 7-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Williams

(a) RESIDENCE NO. 1306 Etting ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ?yrs. ? mos.? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 2-7 1929, 19 C. HAMPSON JONES, M. D.

Per MRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26-29

17

I HEREBY CERTIFY, That I attended deceased from 8-14-25, 19..., to 12-26-29, 19...,

that I last saw h im alive on 12-26-29, 19...

and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Chronic and acute.

More than 8 yrs. ... mos. ... ds.
(duration)

CONTRIBUTORY (Secondary) Arteriosclerosis and hypertension (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic Exam.

(Signed) Marion M. McLean, M. D.

Dec 27, 1929. (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mountlindenburg Penn	12/28 1929
20 UNDERTAKER Daniel Easton	ADDRESS 916 Park

Spec.—2-29-28—L. F. S.—500 Bks.

Lily Gibson

E 52387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52387

CERTIFICATE OF DEATH

100-00

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE (No. Balto ST. 4 N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lily Gibson

(a) RESIDENCE NO. 223 Myrtle Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jefferson Gibson

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER William Hackley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Records
(Address) Balto City Hosp

15 DEC 27 1929, 19 C. HAMILTON JONES
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17

I HEREBY CERTIFY, That I attended deceased from 10-20-, 19 29, to 12-23, 19 29

that I last saw her alive on 12-23, 19 29

and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure
Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

12/24, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Warrington Va	12-28 1929
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52338

118-081 E 52388

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. South Baltimore Gen'l Hosp WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Hartman

(a) RESIDENCE NO. 1220 Highland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hartman

6 DATE OF BIRTH (month, day, and year) March 13-1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40 yrs.	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Friel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary J. Hartman

(Address) 1220 S. Highland ave

15 Dec 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Dec. 26, 1929, that I last saw him alive on Dec. 26, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Incarcerated Post Operative Incisional Hernia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia from Infection & Peritonitis

(duration) 7 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec. 23, 1929

Was there an autopsy? Partial

What test confirmed diagnosis? Operation & autopsy

(Signed) E. A. Liteweger, M. D.

, 19 (Address) 1213 Light Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Dec 30 1929

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager st

Spec.—1-10-21—M&T—1500 Blks.

E 52389 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 52389

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St Agnes Hospital ST. 78-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Barrett

(a) RESIDENCE NO. 4221 Massachusetts Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29 1890

7 AGE Years 39 Months 1 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John J Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary K Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mother Mrs. Mary Barrett

(Address) 4221 Massachusetts Ave

15 2 7 1929 . 19 HAMSON JOHN M. City Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 20 - 1929

17 I HEREBY CERTIFY, That I attended deceased from 12 - 14 . 1929 . to 12 - 20 . 1929.

that I last saw her alive on 12 - 20 . 1929.

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Cyst adenoma Ovary with carcinomatous degeneration

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 12/14/29

Was there an autopsy? no

What test confirmed diagnosis? Microscopic exam

(Signed) Paul Cohen, M. D.

. 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 12/28 1929

20 UNDERTAKER Tempe & Tilley Funeral Home ADDRESS Augusta

CAUSE OF DEATH must be filled in plain terms, so that it may be properly CODED. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52390 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4103 Woodlea ave ST., 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia Eckenrode

(a) RESIDENCE No. 4103 Woodlea Ave ST., WARD Hanover Pa.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Eckenrode

6 DATE OF BIRTH (month, day, and year) Oct 5th 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Margaret Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Anna J Graber
(Address) 4103 Woodlea ave

15 Filed DEC 27 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Dec 26, 1929, that I last saw h[illegible] alive on Dec 26, 1929, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Unknown to me

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

Unknown to me (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sy. Findings

(Signed) J. S. Harding, M. D.

, 19 (Address) 4810 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover Pennsylvania	Dec. 28 1929
20 UNDERTAKER	ADDRESS
Frederick Lescalleet Sons	Fullerton

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52391

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1200 Jenkins St., 11-21 Ward)

2-FULL NAME Horatio Wilson

(a) RESIDENCE NO. 1200 Jenkins St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): 12-12-1924

7 AGE: Years 4 | Months 1 | Days 14 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Alfred Wilson

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Florence Lavan

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md

14 Informant: Alfred Wilson
(Address): 1200 Jenkins

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

By RPR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) H. Blank M. D.
(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem.

DATE OF BURIAL: Dec 28 1929

20 UNDERTAKER: Robert R Williams

ADDRESS: 1515 N. Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Frame 2939 McElderry St Broadway 1234

E 52392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52392

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 Orleans st ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E Roycroft

(a) RESIDENCE NO. 2906 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William

6 DATE OF BIRTH (month, day, and year) Feb 17/1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Bangert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Walber

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Dora McDonald

(Address) 2906 Orleans st

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27th 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-1, 1929, to 12/27, 1929, that I last saw her alive on 12/26, 1929 and that death occurred, on the date stated above, at 10 30/A m.

The CAUSE OF DEATH* was as follows: Endocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frame M. D.

12/27, 1929 Address 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	12/30/1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

Important. See instructions on back of certificate.

DEC 27 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52393

185 V

E 52393

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 608 Harwood Ave St. 27-48 Ward 8

2-FULL NAME George C. Carpenter

(a) RESIDENCE NO. 603 Harwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Mary C. Carpenter

6 DATE OF BIRTH (month, day, and year) June 13/1847

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	82	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Coffee
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Carpenter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Bliss

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant William H. Carpenter
(Address) 5004 Woodcrift Ave

15 12/27/1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia & Anemia - Bed sores.
Accidently fell over rug in home and fractured left femur on Aug 27

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes at home Date of Sept 10/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Carpenter M. D.

12/27/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	12/28/1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 7 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52394

CERTIFICATE OF DEATH

31 E 52391

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5711 Rusk ave. ST. 7-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James M. Chambers

(a) RESIDENCE NO. 5711 Rusk ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Single~~ Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Kearney Chambers

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dock Master 18

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles C. Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Fuerstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Chambers (wife)

(Address) 5711 Rusk ave.

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

Per

2 7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.25.29.

17 I HEREBY CERTIFY, That I attended deceased from June 1929, 19..., to 12.25.29, 19...

that I last saw h... alive on 12.25.29, 19...

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal Tuberculosis.

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Endocarditis.

(duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic

(Signed) Philip B. Fowler, M. D.

12.27.29. 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Dec. 28 1929

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

Spec.—1-12-23—M&T—500 Blks.

E 52395 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 38 E 52395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary WARD) 69 9

2-FULL NAME Mr. William Venable

(a) RESIDENCE NO. 1024 Harford Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Gertrude

6 DATE OF BIRTH (month, day, and year) 3-22-1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) — 050

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Venable

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr C R Cole

(Address) 6017 Harford Ave

15 Dec 28 1929 G. HAMPSON JONES, M. D., Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec. 27, 1929, that I last saw him alive on Dec 27, 1929, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency with compensated failure

(duration) — yrs. — mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann of spinal fluid

(Signed) Vernon K Norwood, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 12/30/1929

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

TION IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52396

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 90 4-25

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T. Reeds

(a) RESIDENCE NO. 638 W. Fayette ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Reeds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Perina William

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 19

C. HAMPSON JONES, M. D.

Registrar

2 8 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17

I HEREBY CERTIFY, That I attended deceased from 7-21-28, 19..., to 12-23-29, 19...,

that I last saw him alive on 12-23-29, 19...

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) more than 1 1/2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 12 ds.

18 Where was disease contracted If not at place of death? 1. at Home 2. In Hospital

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) J. Warwick Hall, M. D.

. 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ....

DATE OF BURIAL DEC 27 1929

20 UNDERTAKER Commissioner Health,

ADDRESS ....

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52397

CERTIFICATE OF DEATH

38 E 52397

1—PLACE OF DEATH Balto City Hospl

REGISTERED NO.

CITY OF BALTIMORE: (No. 1 Balto Md ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Francis

(a) RESIDENCE NO. 1304 St Matthew ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) Balto City Hospitals

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

8 1929 1203

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-29

17 I HEREBY CERTIFY, That I attended deceased from 11-20-29, to 12-23-29,

that I last saw h/ alive on 12-22-29,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Generel Paralysis of Insane

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Serological & Clinical

(Signed) Amy Freedman, M. D.

12/23 19 29 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 27 1929 19

20 UNDERTAKER

ADDRESS

Commissioner Health,

Cor.—10-10-29—A Co.—100 Bks.

E 52398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 52398

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2013 Cecil Avenue St., 9-18 (Ward)

2-FULL NAME Anna O. Duval

(a) RESIDENCE NO. 2013 Cecil Avenue St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Arthur P. Duval

6 DATE OF BIRTH (month, day, and year) February 2, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Day Onion

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A. Buckmiller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Miss Virginia W. Duval
(Address) 2013 Cecil Avenue

15 Filed 2-8-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
accidently fell on street & fractured femuer Nov 21/29
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. K. Hall, M. D.

12/28/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: 12/28 19 29

20 UNDERTAKER: Henry W. Meads & Son — ADDRESS: 805 W. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Rear of 1800 block Light St. 11-7 Ward)

2-FULL NAME Alexander Gross.

(a) RESIDENCE NO. 19 E. Centre St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~Widowed, or Divorced~~ HUSBAND of ~~WIFE of~~ Jennie M. Gross.

6 DATE OF BIRTH (month, day, and year) October 28, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk, Consolidated
(b) General nature of industry, business, or establishment in which employed (or employer) Engineering Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Jennie M. Gross. (wife)
(Address) 19 E. Centre St.

15 Filed 12 8 1929 C. HAMPSON JONES, M. D., Registrar. per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) December 25, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas M. Howard, M. D.

12/26 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 28 1929
20 UNDERTAKER	ADDRESS
Wm J. Tickner & Sons	North & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52460 HEALTH DEPARTMENT—CITY OF BALTIMORE 100 E 52460

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Saubud & Green ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Marie Sparks

(a) RESIDENCE NO. 2029 Harlem ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct. 18 1929

7 AGE — Years | Months: 2 | Days: 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Donald C. Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Irene McAllister

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Covington Va

14 Informant: Donald C. Sparks.

(Address) 2029 Harlem Ave.

15 Filed DEC 28 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27, 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 26, 19 29, to Dec 27, 19 29,

that I last saw h. alive on Dec 27, 19 29

and that death occurred, on the date stated above, at 5:15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson M. D.

Dec 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Monkton-Balto Co Md — DATE OF BURIAL: Dec 29 1929

UNDERTAKER: Wm. Fleckenstein Sons — ADDRESS: York & Pa

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52401 45 E 52401

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hosp. REGISTERED NO. 15-59

CITY OF BALTIMORE: (No. Fayette & Fulton ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Watts

(a) RESIDENCE NO. 2528 Penna. Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) [redacted] Cora Watts

6 DATE OF BIRTH (month, day, and year) April 1 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Bank

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant C. C. Watts
(Address) Pikesville.

15 12 8 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/14/29, 19..., to 12/27/29, 19..., that I last saw h[redacted] alive on 12/27/29 19... and that death occurred, on the date stated above, at 545 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Carcinoma of ileum with metastasis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & clinical picture

(Signed) M. B. Schreiber, M. D.

19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel Cem	Dec 29 1929
20 UNDERTAKER Josiah Ryder	ADDRESS 1600 W. North Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12 E 52462

1—PLACE OF DEATH

REGISTERED NO. 1950

CITY OF BALTIMORE: (No. 2421 Brentwood ST. (If not in a hospital, give WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mathew Johnson

(a) RESIDENCE NO. 2421 Brentwood ST., ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Johnson

6 DATE OF BIRTH (month, day, and year) Unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Alex. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hannah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mattie Johnson

(Address) 2421 Brentwood ave

15 Filed 2 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1927, to Dec 25, 1929, that I last saw h— alive on Dec 25, 1929 and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Ex —

(Signed) P. Garland Cummings, M. D.

Dec 28, 1929 (Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Dec. 29 1929

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Lashland ave

Important: See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52403 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52403

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Ellen Dosh

(a) RESIDENCE NO. Middleborough Stemmers Run P.O. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE Henry L. Dosh

6 DATE OF BIRTH (month, day, and year) Jan 10, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	77	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cleveland

PARENTS

10 NAME OF FATHER John Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records

(Address) Mercy Hosp.

15 Filed 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26-29

17 I HEREBY CERTIFY, That I attended deceased from 12-22, 1929, to 12-26, 1929, that I last saw her alive on 12-26, 1929 and that death occurred, on the date stated above, at 5.55 p. m.

The CAUSE OF DEATH* was as follows:

Probable Carcinoma Bladder ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

12/26 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 28 1929
20 UNDERTAKER	ADDRESS
Harry R Weitzke	401 Edmondson Ave

Important: See instructions on back of Certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52404

CERTIFICATE OF DEATH

29 E 52404

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Cathedral ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Simpson.

(a) RESIDENCE NO. 1000 Cathedral ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie S. Simpson

6 DATE OF BIRTH (month, day, and year): 12-28-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	11	30 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Building Contr 016

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Forfor Scotland.

PARENTS

10 NAME OF FATHER: William Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Forfor Scotland.

12 MAIDEN NAME OF MOTHER: Margaret Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Edinburg Scotland

14 Informant: Dr. W. A. Simpson.
(Address) 1000 Cathedral St. Baltimore Md.

15 FILED 12-29-29, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-27-1929

17 I HEREBY CERTIFY, That I attended deceased from July, 19 27, to 12-27, 19 29,

that I last saw him alive on 12-27, 1929

and that death occurred, on the date stated above, at 2.35 p. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis; complicated by hemiplegia

(duration) 5 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Virginia.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure Tension

(Signed) W. A. Simpson, M. D.

19 (Address) 1000 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va.	Dec. 28 1929
20 UNDERTAKER: Harry N. Witzke	ADDRESS: 4101 Edmondson Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52405 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 52405

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ——— ST., 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis Winston.

(a) RESIDENCE NO. 202 E. Reed ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75(?)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Phillip Winston.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mathews McKee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed 2 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1929, to Dec. 27, 1929, that I last saw him alive on Dec 27, 1929 and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) Unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Harris M. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL DEC 28, 1929

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52406

CERTIFICATE OF DEATH

44 E 52406

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat (ST.) 98-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agatha Schmidt

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home duties

(c) Name of employer Home duties

9 BIRTHPLACE (city or town) Unknown
(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Poland

14 Informant Mt Hope Records
(Address) Mt Hope Retreat

15 Filed 2 8 1929, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27. 1929

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1925, to Dec 27, 1929, that I last saw h[illegible] alive on Dec 27, 1929 and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Melancholia

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Mullen F. Hill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Dec 30 1929
20 UNDERTAKER	ADDRESS
John H Weber	401 Chester Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52407

CERTIFICATE OF DEATH.

153 E 52407

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 635 W. Saratoga St. 4-25 Ward)

2-FULL NAME Joseph Crocetti

(a) RESIDENCE NO. 635 W. Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-5-29.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Vincent Crocetti

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Italy.

12 MAIDEN NAME OF MOTHER Lena Scarto

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland.

14 Informant Lena Crocetti

(Address) 635 W. Saratoga St.

2 8 1929 C. 19 H. Hewson Jones, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 27 1929

17

I HEREBY CERTIFY, That I attended deceased from December 24, 1929, to December 27, 1929, that I last saw him alive on December 27, 1929, and that death occurred, on the date stated above, at 4:37 a.m.

The CAUSE OF DEATH* was as follows:

Malignancy Cellulitis of abdomen

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY none
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Surgical Signs & Symptoms

(Signed) Chester Rixland, M. D.

12-27-1929 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

New Cathedral Cemetery 12/28 1929

20 UNDERTAKER — ADDRESS

George F. Ruth 1735 Hanford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52408

CERTIFICATE OF DEATH

11 VE 52408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 415 N Linwood St., Ward 11)

2-FULL NAME Mary C Hullinger

(a) RESIDENCE NO. 415 N Linwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Dec 24 1917

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
12		3 2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Willinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary C. Ruth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Louis Willinger
(Address)

15 Filed , 19 G. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Acute Indigestion
Stom & Dis
(duration) 2 yrs. 2 mos. 2 ds.
CONTRIBUTORY (Secondary) Cardiac Dilation
(duration) yrs. mos. 12 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? By History

(Signed) M. D.

, 19 (Address) 1430 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec 30 1929

20 UNDERTAKER Frank V. Pa[illegible]one

ADDRESS 2816 E. Balto St

Spec. 2-29-28—L. F. S.—500 Blks.

E 52409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

106-081

E 52409

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 4215 Euclid Ave (ST.) 28-11 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel C Maconachy

(a) RESIDENCE NO. 4215 Euclid Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Feb 3-1919

7 AGE: Years —; Months 10; Days 23; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER C. Read Maconachy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Madeline Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant C. Read Maconachy

(Address) 4215 Euclid Ave

15 Filed ..... 19 ..... Registrar .....

C 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 26, 1929, that I last saw h[illegible] alive on Dec 26, 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute pharyngitis & laryngitis

CONTRIBUTORY (Secondary) Acute fulminating bronchopneumonia (duration) yrs. mos. 5 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) J. T. Kyper, M. D.

, 19 (Address) 3321 Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 12/28 1929

20 UNDERTAKER Chas. P. Bowers Son — ADDRESS 1004 Park Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52410

CERTIFICATE OF DEATH

38 E 52410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH James I. Batchelor

City of Baltimore: (No. St. Joseph Hospital St. 10-71 Ward)

2-FULL NAME James I. Batchelor

(a) RESIDENCE NO. 117 Collins St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Olive Mary Batchelor

6 DATE OF BIRTH (month, day, and year) Aug 1/1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	51	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Walter Batchelor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Rose Lynch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Olive Mary Batchelor
(Address) 117 Collins St

15 Filed ....., 19.... C. HAMPSON JONES, Registrar
By .....

2 8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Cardiac Vascular Lesion

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History at Hospital

(Signed) [illegible], M. D.

2/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 12/30/1929

20 UNDERTAKER Chas. C. Grauel & Son — ADDRESS W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

E 52411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 52411

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 932 Hanford Ave St. 10-14 Ward)

2-FULL NAME John Louis Weir

(a) RESIDENCE NO. 932 Hanford Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1/29

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
			26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Willie Weir

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Ruth Baylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Ruth Weir
(Address) 932 Hanford Ave

15 Filed 18 C. HAMPSON JONES, M. D., Registrar

12 8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Gastro intestinal Indigestion
(Bowels Tied)
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. H. Brown, M. D.
12/27, 1929 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem — DATE OF BURIAL 12-28 1929

20 UNDERTAKER Byron & Wright — ADDRESS 1218 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52412

CERTIFICATE OF DEATH

46 E 52412

1—PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Gasway (Hudson)

(a) RESIDENCE NO. 16 S. Spring ST., WARD A-2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mose

6 DATE OF BIRTH (month, day, and year) Dec 18-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Del

PARENTS

10 NAME OF FATHER Geo Priteman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Hester Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Records
(Address)

15 Filed 2 8 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Dec 26, 1929, that I last saw her alive on Dec 25, 1929 and that death occurred, on the date stated above, at 7.08 P m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis probably originating in endometritis following explosion of submucous myoma of uterus (duration) about 5 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma Uterus & endometritis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Peritonitis contracted at home

Did an operation precede death? Yes Date of Nov. 19, 1929 (D+C)

Was there an autopsy? Yes, No. 11246, Dec. 26, 1929

What test confirmed diagnosis? Autopsy.

(Signed) Raymond C. Jenner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
George Town Del	12/28/29

20 UNDERTAKER Joseph Ahrens

ADDRESS 721 Berry

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 227 N Broadway St., 76 Ward)

2-FULL NAME Emma Kastner

(a) RESIDENCE NO. 227 N Broadway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Box factory
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Rammel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Kistner
(Address) 227 N Broadway

Filed ..... 19.... ..... Registrar

C 28 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Contributory (Secondary) (duration) yrs. mos. 14 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? By Clinical History

(Signed) C. C. Straub, M. D.

. 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel cem.	12/28/1929

20 UNDERTAKER Robt Turner

ADDRESS 1442 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52414

CERTIFICATE OF DEATH

101-001

E 52414

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1602 Prestman St., 15-21 Ward)

2-FULL NAME Thos Robinson

(a) RESIDENCE NO. 1602 Prestman St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred ... yrs. ... mos. ... ds. How long In U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Dec 4-1929

7 AGE: Years ... Months ... Days 24 (22) IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none (old)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) .....

PARENTS

10 NAME OF FATHER Thos Robinson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Chapman

13 BIRTHPLACE OF MOTHER (city or town) D. C.
(State or country)

14 Informant Annie Robinson
(Address) 1602 Prestman

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar
Dec 28 1929 (20) Deputy Registrar MH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) H. Tabish, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 19

20 UNDERTAKER: Commissioner Health.

ADDRESS DEC 27 1929

For Com. E. WOODALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52415

CERTIFICATE OF DEATH.

E 52415

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline & oliver ST., WARD 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Buchanan

(a) RESIDENCE NO. 2607 Ellsworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W L	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-24-25.

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ... min.
—				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER W. F. Buchanan

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Hospital Records
(Address)

15 12 28 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-26-29, 19 ... to 12-27-29, 19 ..., that I last saw h[illegible] alive on 12-27-29, 19 ..., and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature (5 mos)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M H Hendrix, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 DEC 29 1929

20 UNDERTAKER Commissioner Health

ADDRESS

FILE FOR 5 YEARS

2 8 1929 208

IMPORTANT.—CAUSE OF DEATH to be plain (e'tics, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 90 E 52416

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 W Franklin ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Johnson

(a) RESIDENCE NO. 1504 W Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred (yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (er) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) May 2. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Mamie Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Jennie Stalk

(Address) 1504 W Franklin St

15 Filed 2 8 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 19 29, to Dec, 19 29, that I last saw h[illegible] alive on Dec 26, 19 29 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — DATE OF BURIAL Dec 28 1929

20 UNDERTAKER Joseph A Lively — ADDRESS 409 N Mount St

Spec.—2-29-28—L. F. S.—500 Bks.

E 52417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 52417

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N Dallas ST., 6-4 WARD)

2—FULL NAME Ardella E Sommerville Hill

(a) RESIDENCE NO. 104 N Dallas ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

3a If married, widowed, or divorced (or) WIFE of John Hill

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Sommerville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant Annette Hill

(Address) 104 N Dallas St

15

Filed 2 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct ..... 19 29 to Dec 26 ..... 19 29, that I last saw h[illegible] alive on Dec 25 ..... 19 29, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? uncertain

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R F Young, M. D.

Dec 27 19 29 (Address) 429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL Dec 30 1929

20 UNDERTAKER Edward Bryan — ADDRESS 663 Orleans St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52418

CERTIFICATE OF DEATH

#52418

E 52418

1—PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Greene St. #30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mammie Pussey

(a) RESIDENCE NO. Princess Anne, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 FEB 28 1929, 19 H. J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28/29.

17

I HEREBY CERTIFY, That I attended deceased from 10/6/29, 19, to 12/28/29, 19,

that I last saw her alive on 12/28/29, 19

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Post operative shock

Chronic nephritis - T. B. Lung infection

Secendary anemia

Osteomyelitis of Ribs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/28/29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. J. Watson Jr Stafford, Md.	
20 UNDERTAKER	ADDRESS
Princess Anne Md	12/31/29.

IMPORTANT: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

70 E 52419

REGISTERED NO.

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ST. WARD) 22-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel J. Smith

(a) RESIDENCE NO. 804 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie W. Smith

6 DATE OF BIRTH (month, day, and year) Dec 29, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	11	29 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work News dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Wm. E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Hospital Records

(Address)

15 Filed DEC 29 1929 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929, to Dec 27, 1929, that I last saw him alive on Dec 27, 1929 and that death occurred, on the date stated above, at 5:40 p. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings

(Signed) M. Franklin Bibbins, M. D.

12/27, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 30 1929
20 UNDERTAKER	ADDRESS
Fred A. Wannemacher	703 Hamilton

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52420

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH John J. Foley 9-46

REGISTERED NO. E 52420

City of Baltimore: (No. 757 Bartlett Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Foley

(a) RESIDENCE NO. 757 Bartlett Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Helen T. Foley

6 DATE OF BIRTH (month, day, and year) Feb 20/1003

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	10	11 7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Machinist 031
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Martin Foley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Leary

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Edgar M. Foley (son)
(Address) 757 Bartlett Ave

15 Filed DEC 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. S. H. Cullen, M. D.

12/29/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 30 1929

20 UNDERTAKER Faid & Stevenson

ADDRESS 703 N. [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52421

CERTIFICATE OF DEATH

1881-103 E 52421

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St., 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward D. Rodgers

(a) RESIDENCE NO. 3103 N. Calvert St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Estella E. Rodgers

6 DATE OF BIRTH (month, day, and year): June 21. 1879

7 AGE: Years 50 | Months 6 | Days 7 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Registered Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9 BIRTHPLACE (city or town):
(State or country): Ireland

PARENTS

10 NAME OF FATHER: Edward Rodgers

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cecilia Mc Neilly

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Ireland

14 Informant: Mrs Estella E. Rodgers
(Address): 3103 N Calvert St

Filed DEC 29 1929 H. JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cut. Hemorrhage Traumatic due to chest (R) and Ribs fx crushed on to run over by auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract R. Scapulae Fract L. Ankle (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Ave & Charles

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D.D. Freeman, M. D.

12/28 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 31 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1317 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 52422

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52422

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Balto City Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Kirby

(a) RESIDENCE NO. 1206 Bentwood Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 015

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown Md.

PARENTS

10 NAME OF FATHER Patrick Kirby

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen McCusker

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Canada

14 Informant Hospital Record

(Address) Baltimore City Hospitals

15 Filed DEC 29 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-11, 1929, to 12-26, 1929, that I last saw h. alive on 12-26 1929 and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis of Kidneys

" of Bladder

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Fred M. Dunkwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/30/1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul st

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Harry Seigel

E 52423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 ✓

E 52423

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Seigel

(a) RESIDENCE NO. 2103 E. Balto. St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Seigel

6 DATE OF BIRTH (month, day, and year) Dec. 25th -1871

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	58		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant

(Address)

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns over large surface of body. Clothes caught fire from lighted cigarette in bed, at Aged Home, Belvidere & Green Spring Aves.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Sappington, M. D.

12/28/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Rosedale — DATE OF BURIAL 1/2/29 1929

20 UNDERTAKER Jack Lewis 1439 E. Balto St — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52424

CERTIFICATE OF DEATH.

84 E 52424

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 482-30 ST. WARD)

2-FULL NAME Martha Bode

(a) RESIDENCE NO. 542 N. Conway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bode

6 DATE OF BIRTH (month, day, and year): Aug 1897

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
32	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of Industry, business, or establishment in which employed (or employer): 63

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Adam's Town Md

PARENTS

10 NAME OF FATHER: Lansing Bowrings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Luanda Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Wm Bode

(Address): 542 W Conway st

15 Filed ... C. HAMPSON JONES, M. D. Registrar

Per ...

C 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/23/29 19

17 I HEREBY CERTIFY, That I attended deceased from 12/27/29 . 19 . to 12/28/29 . 19 . that I last saw her alive on 12/28/29 . 19 . and that death occurred, on the date stated above, at 9:15 A . m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 12 Hours

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. Friedrich, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington Mt Ec

DATE OF BURIAL: Dec 30 1929

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52425

CERTIFICATE OF DEATH

31 E 52425

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto City Hosp ST. 69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Frisby

(a) RESIDENCE NO. 223 N. Bond ST., E. 7th WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No data

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) No data

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER No data

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Josephine Frisby

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Baltimore City Hosp (Address) Eastern Ave

15 Filed DEC 29 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Dec, 25, 1929, that I last saw him alive on Dec 24, 1929 and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray

(Signed) Jas Arnold Jr, M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Crm

DATE OF BURIAL 12-29 1929

20 UNDERTAKER Byrom & Inger

ADDRESS 1218 McElderry St.

Spec.—2-29-28—L. F. S.—500 Bks.

E-52426. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E-52426

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 357 Rose Bank Ave ST. 27-48 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A Hawthorne

(a) RESIDENCE NO. 357 Rose Bank Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
M	W	M

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane G Hawthorn

6 DATE OF BIRTH (month, day, and year) July 26 90

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Hawthorne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Jane G Hawthorne

(Address) 357 Rosebank ave

15 Filed 2 9 1929 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 19 1929 to Dec 27th 1929

that I last saw him alive on Dec 27 1929

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

Pulmonary "

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Sputum Positive

(Signed) Jefferson Brick M. D.

12/27 1929 (Address) 5 Club Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greene Presbyterian cemetery

DATE OF BURIAL Dec 30 1929

20 UNDERTAKER W M Routson

ADDRESS 2235 N Mt

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 52427

CERTIFICATE OF DEATH

185 E 52427

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 167 Alice Anne St., 2-4 Ward)

2-FULL NAME Alex Yoter

(a) RESIDENCE NO. 167 Alice Anne St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 25 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4 1874

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	55	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labor 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Holland

PARENTS

10 NAME OF FATHER ? Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Holland

14 Informant Adam J. Hoffman
(Address) 624 S. Ann St

15 Filed 19 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Fracture of Skull, Multiple Bruises acc Fall down Stairs

(duration) hrs. mos. 2 hr ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 hr

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? Date of —

Was there an autopsy? 12/29

What test confirmed diagnosis? Hist Exam

(Signed) J. C. Stades, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL Dec 30 1929

20 UNDERTAKER M. W. E. Dupplas — ADDRESS 31 Lombard

DEC 28 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52428

CERTIFICATE OF DEATH

49 E 52428

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 McCulloh ST., 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Thomas Johnson

(a) RESIDENCE NO. 2316 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 10 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Iva Johnson

6 DATE OF BIRTH (month, day, and year): Feb 22, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 070

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Ann —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Iva Johnson (Address) 2316 McCulloh

15 Filed ... 19 ... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27, 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924, to Dec 27, 1929, that I last saw h[illegible] alive on Dec 26, 1929 and that death occurred, on the date stated above, at 12.35 A m.

The CAUSE OF DEATH* was as follows:

Coated Hemorrhage

(duration) ... mos. 3 ds.

CONTRIBUTORY (Secondary) Laryngeal Pneumonia

(duration) ... yrs. 10 mos. ... ds.

18 Where was disease contracted if not at place of death? 2316 McCulloh

Did an operation precede death? Yes Date of Aug 16 29

Was there an autopsy? No

What test confirmed diagnosis? X-Ray - Physical

(Signed) Wm. H. Wright, M. D.

12/27 1929 (Address) 1209 Forrest

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL 12/29 1929

20 UNDERTAKER: Samuel Schmeltz — ADDRESS 1128 N Eutaw St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52429

CERTIFICATE OF DEATH

100-001

E 52429

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1705 Byrd St. St.) 24-34 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annette C. Henderson.

(a) RESIDENCE NO. 1705 Byrd St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 18, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md,
(State or country)

PARENTS

10 NAME OF FATHER Charles Henderson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Catherine Hartline.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Catherine Henderson. (mother)
(Address) 1705 Byrd St.

15 Filed ....., 19.. H. HANSON JONES, M. D.
Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 28, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry find that said deceased came to her death
(Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

unknown.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leonhardt, M. D.

12/28 19 29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 12/30 1929

20 UNDERTAKER John J Fahey Son, — ADDRESS 1318 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 52430
1—PLACE OF DEATH

REGISTERED NO. E 52430

CITY OF BALTIMORE: (No. 2803 E. Chase St. ST. 4-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James L. Simmons

(a) RESIDENCE NO. 2803 E. Chase St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 19 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward I. Simmons

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mabel L. Davis

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14
Informant Mr. Edward I. Simmons
(Address) 2803 E. Chase St

15
Filed 12 29 1929 E. H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1929

17
I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Dec 28, 1929, that I last saw him alive on Dec 28 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B P Herzog MD, M. D.

12/30, 1929 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL 12/30 1929

20 UNDERTAKER I. Frew McCully

ADDRESS 130 E. Front

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52431

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 7-28 (Ward)

2-FULL NAME Mrs. Lillie Sumers

(a) RESIDENCE No. 2048 Ulkens Ave. City WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myer Sumers

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 44 Years Months Days If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Pierre Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bala —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Myer Sumers (Address) 2048 Ulkens Ave

15 Filed 2 1929 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-17 1929 to 12-29 1929 that I last saw her alive on 12-29 1929 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic appendicitis, Obs Laceration of perineum

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Embolism (Respiratory)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Yes Date of 12/19/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Nicholas D'Annelli M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Wash. Road

DATE OF BURIAL 12-29 1929

20 UNDERTAKER Joel Lowy

ADDRESS 1739 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52432 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 52432

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 N. Calvert ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia T. Fenton

(a) RESIDENCE NO. 2110 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William B. Fenton

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russell County (State or country) Virginia

PARENTS

10 NAME OF FATHER Thaddeus P. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Sarah Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant T. P. Thomas

(Address) 1111 N. Eutaw St.

15 Filed DEC 29 1929 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28/29

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929 to Dec 28, 1929

that I last saw h[illegible] alive on Dec 28, 1929

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 1 da.

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H H Means, M. D.

Dec 25, 1929 (Address) 2405 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Burial Ground	12/30 1929

20 UNDERTAKER Henry H. Means & Son ADDRESS 505 N. Calvert St.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 109-002 ✓ E 52433

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 N. Charles ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie B. Seidewitz

(a) RESIDENCE NO. 919 N. Charles ST., WARD Texas Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. 3 mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edwin Seidewitz

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert H. Bussey

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Steffens

13 BIRTHPLACE OF MOTHER (city or town) Charleston
(State or country) S. C.

14 Informant Dr. Benj. B. Bussey
(Address) Texas, Md.

15 Filed 12-30-29 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Dec 27, 1929, that I last saw her alive on Dec 26, 1929, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Septic Sore throat + Septic endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edith Hayward, M. D.

19 (Address) 1129 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cem. Texas — DATE OF BURIAL: 12/30 1929

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Important. See instructions on back of certificates.

E 52434 — 100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 52434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1615 Park ave St. 14-20 Ward)

2-FULL NAME Lenwell S. Watts

(a) RESIDENCE NO. 1704 Park ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lula Blunden Watts

6 DATE OF BIRTH (month, day, and year): Jany 11 1871

7 AGE: Years 58 Months 11 Days 16. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Mrs. Lenwell S. Watts

(Address) 1704 Park ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry) find that said deceased came to

death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Hemorrhage due to gunshot wound of brain

(duration) yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home 1615 Park Pl.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Blunden M. D.

Dec 29 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Dec 31 1929
20 UNDERTAKER	ADDRESS
John A. Mitchell & Sons	1600 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 52435

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52435

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Eaton Ave ST. 14-21 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Henning

(a) RESIDENCE NO. 332 Piedmont ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. S. Henning

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 83 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Jenkins Memorial Hospital

15 Filed 1929 Reg. by H. LEWELLYN JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23 1929 to Dec. 27, 1929, that I last saw h— alive on Dec. 26, 1929, and that death occurred, on the date stated above, at 12-15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brunner, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec 28 1929

20 UNDERTAKER: Whitehead Bros.

ADDRESS: Eutaw Place

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

232044

E 52436

CERTIFICATE OF DEATH

+ 49

REGISTERED NO. E 52436

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME James A Hulett

(a) RESIDENCE NO. Lexington Ky ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Nov-1-58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky

PARENTS

10 NAME OF FATHER Edmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Anne E Burch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 29 1929 LAWSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-29-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 11 1929, to Dec 29, 1929, that I last saw him alive on Dec 29, 1929, and that death occurred, on the date stated above, at 5 '0 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Hypostatic pneumonia)

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Lexington, Ky.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy

(Signed) H Smith, M. D.

12/29, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lexington Ky	Dec 29 1929
20 UNDERTAKER John O Mitchell Sons	ADDRESS 1911 Eutaw Place

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

52437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

t 84 E 52437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hosp.

CITY OF BALTIMORE: (No.) ST. 9-17 WARD)

2-FULL NAME John J Nolan

(a) RESIDENCE NO. 102 Putty Hill Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? Life yrs. - mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 5 1926

7 AGE — Years: 3 Months: 7 Days: 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John J. Nolan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Eleanor M. Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Mr John J Nolan 102 Putty Hill Ave

15 Filed DEC 29 1929 19 THEODORE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 28 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 26 1929 to Dec 28 1929.

that I last saw him alive on Dec 28 1929.

and that death occurred, on the date stated above, at 12.20 Pm.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Shock - Respiratory Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/24/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S H Barranco M. D.

12/28/1929 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec. 30 1929

20 UNDERTAKER: Henry Hauch Sons Inc — ADDRESS: 1301 E Eager

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52438

CERTIFICATE OF DEATH

101-001 ✓

E 52438
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Frank C. Bory 1-13

City of Baltimore: (No. St. Joseph Hospital St., Ward)

2-FULL NAME Frank C. Bory

(a) RESIDENCE NO. 940 N. Broadway St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha M. Bory

6 DATE OF BIRTH (month, day, and year) April 10/1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	8	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 0-57
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Ferdinand Bory

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Bertha M. Bory
(Address) 940 N. Broadway

15 Filed DEC 29 1929 19 H. Hilton JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(doration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/28/29 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Dec. 30 1929

20 UNDERTAKER Henry Stark & Sons Inc. — ADDRESS 1301 E Eager St

DO NOT FAIL to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 52439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) In front 1705 N. Fulton St., (Ward) 90-14

2-FULL NAME John J. Fiddes

(a) RESIDENCE NO. 1111 Greenmount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes

6 DATE OF BIRTH (month, day, and year) Nov 26 - 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Asst-Supt of
(b) General nature of industry, business, or establishment in which employed (or employer) Greenmount Cemetery Co
(c) Name of employer

9 BIRTHPLACE (city or town) England
(State or country)

PARENTS

10 NAME OF FATHER Robt S. Fiddes

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Dorn

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Jos. E. Fiddes
(Address) 1111 Greenmount Ave

15 Filed DEC 29 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Arteriosclerosis (duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Fred Fleischmann, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Dec 31 1929

UNDERTAKER Henry Hoech Sons, Inc. — ADDRESS 1301 E. Eager St

Instructions: Fill in all items, if possible. Use ink and write plainly. Avoid abbreviations. Avoid using the word "Stated." PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 52440

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 513 Westgate Road (Ward) 28-71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles T. Brandt

(a) RESIDENCE NO. 513 Westgate Road St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine E. Brandt

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Herman Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Amalia Trautman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine E. Brandt

(Address) 513 Westgate Road

Filed DEC 29 1929 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Dec. 28, 1929, that I last saw him alive on Dec. 24, 1929 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Eugene L. Pessagno, M. D.

12.28. 1929 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec. 30th 1929.
20 UNDERTAKER	ADDRESS
Mr & Mrs. John W. Tenfelde Son	801 W Fayette

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-002 ✓ E 52441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Fremont ~~South Bolton~~ ST., ~~Ward~~)

2—FULL NAME Louis Richter

(a) RESIDENCE NO. 923 Fremont ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 24 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29	1920	Nov.	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

040

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Richter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant August Richter
(Address) 700 Mc. Henry St

15 Filed DEC 29 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26. 29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1929, to December 26, 1929, that I last saw him alive on December 24 1929 and that death occurred, on the date stated above, at 12 30 a/m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia, Lung abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? Yes Date of 11/16/29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E. A. Liebinger, M. D.

19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 31 1929.
20 UNDERTAKER	ADDRESS
M. Funeral John W. Teufel & Son	831 W. Fayette

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52442

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1656 Clifton Ave ST., 8-45 WARD)

2—FULL NAME Thomas Mayer.

(a) RESIDENCE NO. 1656 Clifton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susannah Mayer.

6 DATE OF BIRTH (month, day, and year) 6-14-1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) England.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown.

14 Informant Susannah Mayer.
(Address) 1656 Clifton Ave.

15 Filed , 19 , Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from dec 25, 1929, to dec 26, 1929, that I last saw him alive on dec 26, 1929, and that death occurred, on the date stated above, at 1115 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) High blood pressure

(Duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. F. Zimmermann, M. D.

12/28 1929 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Dec 30 1929.

20 UNDERTAKER Ehrenworth Son

ADDRESS 3615 Chestnut Ave

Important. See instructions on back of certificates.

DEC 29 1929 REC'D JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52443

CERTIFICATE OF DEATH

31 ✓ E 52443

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Joseph P. Reilly 8-16

City of Baltimore: (No. 2328 East North Ave St., Ward)

2-FULL NAME Joseph P. Reilly

(a) RESIDENCE NO. 2328 East North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17/1887

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	42	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Reilly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bessie Owens

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mary Sleysman
(Address) 2020 East Biddle St.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

DEC 30 1929 BLK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/28/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 12/30/1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

NOT SHOULD be carefully supplied. AGE SHOULD be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52444 — CERTIFICATE OF DEATH — 101-001 E 52444

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 924 N. Durham ST. 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vaclav Hocka

(a) RESIDENCE NO. 924 N. Durham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Hocka

6 DATE OF BIRTH (month, day, and year): Sept 28, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Public Schools

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Vaclav Hocka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Barbara Hocka

(Address) 924 N. Durham

15 Filed DEC 30 1929 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 26/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 26, 1929, that I last saw him alive on Dec 26, 1929, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Graef, M. D.

1929 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 30 1929

20 UNDERTAKER: Chas Jackson — ADDRESS: 1708 Eastwood

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

52445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 52445

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Gilmor ST. 19-28 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice Harvey,

(a) RESIDENCE NO. 414 S. Gilmor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cornelius Harvey.

6 DATE OF BIRTH (month, day, and year): June. 9. 1874.

7 AGE: Years 55. Months 6 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Peter Callan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: M. Mackin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Cornelius Harvey. (Address) 414 S. Gilmor st

15 Filed 30 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 26, 1929, that I last saw h[illegible] alive on Dec 26, 1929, and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): none,

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? Cystoscopic Exam Etc.

(Signed) J. Thacher Lord, M. D.

12/28/29 (Address) 888 N Longwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemy.

DATE OF BURIAL: Dec 30 1929

20 UNDERTAKER: Geo. F. Ruth

ADDRESS: 1735 Harford

2

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52446

E 52446 Gov E 52446

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 W. Mulberry ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Dorsey

(a) RESIDENCE NO. 1414 W. Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced, (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jessie Coy

(Address) 1911 McCulloh St

15 Filed DEC 30 1928 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27-1928

17 I HEREBY CERTIFY, That I attended deceased from 11-20-, 1928, to 12-27-, 1928, that I last saw h.. alive on 12-27-, 1928, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John E. L. Campbell M. D.

. 19 (Address) 724 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-30 1928
20 UNDERTAKER Edward Earley	ADDRESS 94 Ca

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 52447 E 52447

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 1726 W. Lanvale St., 16-22 89 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia D. Green

(a) RESIDENCE NO. 1726 W Lanvale St., 16 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Green

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	39	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Carrie Green
(Address) 1726 W Lanvale St

15 Filed DEC 30 1929 HAMILTON JONES, M.D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Smith, M. D.

Dec 29 (Address) Comm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-30 1929
20 UNDERTAKER Daniel Eaton	ADDRESS 916 Pa ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52448

CERTIFICATE OF DEATH

90 E 52448

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 520 Jasper St., 17-25 Ward)

2-FULL NAME Alexander Medley

(a) RESIDENCE NO. 520 Jasper St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	79	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) md

PARENTS

10 NAME OF FATHER Geo Medley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brooks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Phillip E Medley
(Address) 520 Jasper St

15 Filed ..... 19.. C. HARRY JONES, Registrar

By ..... Deputy

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquest

(Signed) Dec 28th J. Chas. Stephen, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 12-30 1924

20 UNDERTAKER Daniel Carter — ADDRESS 814 Park Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION A very important. See instructions on back of certificate.

DEC 30 1924

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52449

65-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO. E 52449

CITY OF BALTIMORE: (No. 1512 Division ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin Cox

(a) RESIDENCE NO. 602 Pitcher ST., WARD 9W

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 9-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Luther Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Linda Rosehell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Luther Cox

(Address) 602 Pitcher St

15 Filed DEC 30 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Dec 28, 1929,

that I last saw him alive on Dec 28, 1929

and that death occurred, on the date stated above, at 3 30 P. M.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical Laboratory

(Signed) [illegible] M. D.

12-28 1929 (Address) 600 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-30 1929
20 UNDERTAKER Daniel Carter	ADDRESS 916 Dames

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52450

CERTIFICATE OF DEATH

165

E 52450 REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1216 N Baltimore St. 18-7th (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Southworth

(a) RESIDENCE NO. 1216 N Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
Husband of
(or) Wife of

6 DATE OF BIRTH (month, day, and year) Nov 9th 1869

7 AGE: Years 60 | Months 1 | Days 19 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lieutenant
(b) General nature of industry, business, or establishment in which employed (or employer) Ret
(c) Name of employer

9 BIRTHPLACE (city or town) Fredericksburg
(State or country) Va

PARENTS

10 NAME OF FATHER Harry Southworth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Elsie Cox

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Harry Southworth
(Address) Fredericksburg Va

15 Filed ..... 19.. C. HERBERT JONES, M.D. Registrar

DEC 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide By taking
Potassium Cyanide
Self administered

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brosius M. D.

12/28. 1929 (Address) 3601 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fredericksburg Va — DATE OF BURIAL: Dec 30 1929

20 UNDERTAKER: John Fields — ADDRESS: 1200 N Fremont Ave

Cor.—10-10-29—A Co.—100 Bkn.

E 52451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1971 E 52451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 15-61 Ward)

2-FULL NAME John F. Steinmetz

(a) RESIDENCE NO. 3012 Clifton Avenue St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. - mos. - ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charlotte Gerold

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	11	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Vice President and
(b) General nature of industry, business, or establishment in which employed (or employer) Treasurer - First
(c) Name of employer Mortgage Bond Asso.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis G. Steinmetz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Staub

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Leo Steinmetz
(Address) 717 W. North Avenue

Filed DEC 30 1929 HAMPTON JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot Shot wound in right chest. Homicide

Few minutes (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Signed W. J. Pilley M.D. Coun, M. D.

. 19 29 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	12/31 1929
20 UNDERTAKER Henry H. Meade and Son	ADDRESS 805 W. Calvert

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 52452 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52452

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) ... (ST.) ... (WARD) 50-28

REGISTERED NO. ...

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stewart Holland

(a) RESIDENCE NO. 1938 W Pratt St ... ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Apr. 3-1908

7 AGE — Years: 21 — Months: 8 — Days: 24 — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): in office

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm W. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Margaret Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs. Mat. Holland

(Address): 1938 W Pratt St

15 Filed DEC 30 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-27 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-26 1929 to 12-27 1929

that I last saw him alive on 12-27 1929

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) George Brenneman M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec 30 1929

20 UNDERTAKER: George L. Schwartz — ADDRESS: 201 Fulton Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—AC—100 Bks.

E 52453

Martha J. Colquitt

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52453

CERTIFICATE OF DEATH

54-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Pronounced dead

City of Baltimore: (No. St. Francis Xg. Hospital 16-22 Ward)

2-FULL NAME Martha J. Colquitt

(a) RESIDENCE NO. 1802 Rayner ave St., Ward Va

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Richmond

6 DATE OF BIRTH (month, day, and year) Feb. 11 - 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Henry Belcher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Richmond

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Walter B. Hood
(Address) 1802 Rayner ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Broode, M. D.

Dec 29, 1929 (Address) 3601 3rd Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va.	Dec 30 1929
20 UNDERTAKER George L. Schwab	ADDRESS 910 Eutaw St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52454

CERTIFICATE OF DEATH

14001

E 52454

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2325 Linden Ave. St.) (13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret C. Heingerling

(a) RESIDENCE NO. 2325 Linden Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Heingerling

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John R. Deuchler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John R. Heingerling

(Address) 2325 Linden Ave.

15 Filed DEC 30 1929 C. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/21/, 1929, to 12/28/, 1929, that I last saw h[illegible] alive on 12/27/, 1929 and that death occurred, on the date stated above, at 6.35 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? None

(Signed) George Abner Bowles, M. D.

12/29, 1929 (Address) 1517 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Dec 30 1929

20 UNDERTAKER W. J. Fickner & Sons

ADDRESS North & Pa

IMPORTANT.—If the death is that of a person who has been employed in any of the principal occupations in which there is a special risk of contracting tuberculosis, such as mining, quarrying, stone cutting, metal grinding, work in cotton, woolen, silk or flax factories, or in the manufacture of clothing, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 52455

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 1724 Ward)

2-FULL NAME Thos. Chew

(a) RESIDENCE NO. 770 Bradley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary.

6 DATE OF BIRTH (month, day, and year) Feb 21-1889

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	40	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Thos. Chew

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jackey

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary Chew
(Address) 770 Bradley

15 Dec 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) ... yr. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Fractured Humerus

Fell in yard of home (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Not Date of Dec 26

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) J. McCauley, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 12/30/29

20 UNDERTAKER Jno. Geo. H. Holland — ADDRESS 1631 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52456

CERTIFICATE OF DEATH

90 ✓ E 52456

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital ST., 15-21 WARD)

2—FULL NAME Flaunie A. Roberts

(a) RESIDENCE NO. St. Mary's Home Fountain & Elmore Sts WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William

6 DATE OF BIRTH (month, day, and year) ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Smith
(Address) 15-45 Aiggle Ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 12 1, 1929, to 12-26, 1929, that I last saw him alive on 10-26, 1929, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

Arteriosclerotic Gangrene

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Sachs, M. D.

12/27, 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamel — DATE OF BURIAL 12/30/1929

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1618 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. B.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52457

CERTIFICATE OF DEATH

90 E 52457

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rudolph Legler

(a) RESIDENCE NO. 123 S. Wolfe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Legler

6 DATE OF BIRTH (month, day, and year) Nov. 17th 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
69	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernest Legler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed C. HAMPSON JONES, M. D. Registrar

C 301929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27-29

17 I HEREBY CERTIFY, That I attended deceased from 12-3-29, 19..., to 12-27-29, 19..., that I last saw him alive on 12-27-29, 19... and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) more than 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Course, autopsy.

(Signed) Theron G. McClean, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Dec 30, 29

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52458

CERTIFICATE OF DEATH.

17 OV E 52458

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Pleasant & Courland St. 27-53 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C. Parker Baker

(a) RESIDENCE NO. 4535 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara E. Baker

6 DATE OF BIRTH (month, day, and year) June 14 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) O'W

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co

(State or country)

PARENTS

10 NAME OF FATHER Charles A. Baker

11 BIRTHPLACE OF FATHER (city or town) Balto. Co

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Davis

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co

(State or country)

14 Informant Mrs Sara E. Baker

(Address) 4535 Falls Rd

15 Filed ....., 19..... C. HAMILTON JONES, M. D.

DEC 30 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Pistol shot wound in Chest.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

Dec. 28 29 (Signed) W. C. Tilley M. D.

Dec. 30 29 (Coroner)

(Address) 1629 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs. ..... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill Cemetery Co Date of Burial Dec 31 1929

20 UNDERTAKER H. S. Marshall ADDRESS 3539 Falls Rd

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Mary Simms

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52459

CERTIFICATE OF DEATH

24001

E 52459

1—PLACE OF DEATH 1008 E Shaw St. REGISTERED NO.

CITY OF BALTIMORE: (No. 1008 ST 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Simms

(a) RESIDENCE NO. 1008 E Shaw ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Simms

6 DATE OF BIRTH (month, day, and year) Oct 9, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A, A, Co Md

PARENTS

10 NAME OF FATHER Albert Burley

11 BIRTHPLACE OF FATHER (city or town) (State or country) A, A, Co. Md

12 MAIDEN NAME OF MOTHER Annie Sampson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co. Md

14 Informant Ollie Shipley

(Address) 1008 Shaw St

15 Filed DEC 30 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 25, 1929, that I last saw h[illegible] alive on Dec 25, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

Dec 29 1929 (Address) 711 E. Shaw St

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch A A Co. Md	Dec 30 1929
20 UNDERTAKER	ADDRESS
N. L. Brown & Son	1011 N. Monty

IMPORTANT—Before burial, removal or cremation of body, a permit must be obtained from the Registrar. Before filing this certificate, see that it is complete in every particular, as it may be impossible to obtain some of the information after the body has been buried. Every question on both sides of this certificate must be answered, or a reason given for failure to do so, as the certificate will be returned for completion if any important item is omitted. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52460

CERTIFICATE OF DEATH.

57 ✓ E 52460

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp St.) Ward) 213

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Gillette

(a) RESIDENCE NO. 924 N. Wolfe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 1910

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

10 NAME OF FATHER Moses Gillette

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Marie Gillette

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

PARENTS

14 Informant Mrs. Gillette

(Address) 924 N. Wolfe St.

15 Filed DEC 30 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] (Coroner) M. D.

12/30/29 10 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Dec. 30 1929

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1715 Ashland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

52461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

114 E 52460

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1023 Bush St.) (WARD 21-28)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Katzka

(a) RESIDENCE NO. 1023 (Usual place of abode) Bush ST., WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Katzka

6 DATE OF BIRTH (month, day, and year) July 24th 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hungaria

PARENTS

10 NAME OF FATHER Nicholas Willar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria.

12 MAIDEN NAME OF MOTHER Annie Marku

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Mr Andy Gutay (Address) 1023 Bush St

15 Filed 30 1929 C. HOWARD JONES, M. D. Registrar By RHH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1929. to Dec 28 1929. that I last saw h[illegible] alive on Dec 28 1929 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

CONTRIBUTORY (Secondary) Oedema of Lung (duration) yrs. 2 mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Normal

(Signed) J. Pirotto, M. D.

12-29. 1929 (Address) 220 26. North Ca.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Brooklyn Md.

DATE OF BURIAL Dec 31st 1929

20 UNDERTAKER John J Kovar & Son

ADDRESS 901 Hollins St.

C OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 52462

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3832 Sifth ST., Brookfield 5-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry W. Gabe

(a) RESIDENCE NO. 3832 Sifth ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 11. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Henry Gabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Frances Ernest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Mrs. Gabe Mother

(Address) 3832 Sifth St.

15 Filed DEC 30 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/27/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1929, to Dec 27 1929, that I last saw him alive on Dec 26 1929, and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular

(duration) 1 yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. S. Wolfson M. D.

(Address) 1 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL Dec. 29 1929

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St.

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

52463 Thomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 52463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 E. Center St. 11-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edwin Thomas

(a) RESIDENCE No. 106 E. Center ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor A Thomas

6 DATE OF BIRTH (month, day, and year) Centenarian

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	43 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Stephen Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Greene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Eleanor A Thomas (Address) 106 E. Center St.

Filed DEC 30 1929. 15 per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/27 1929

17

I HEREBY CERTIFY, That I attended deceased from 12/1, 1929, to 12/27, 1929, that I last saw h alive on 12/26, 1929, and that death occurred, on the date stated above, at 3 20 Am

The CAUSE OF DEATH* was as follows:

Hypostatic Pulmonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Rhett, M. D.

12/28 1929 (Address) 214 D St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel — DATE OF BURIAL Dec 30 1929

20 UNDERTAKER John W Henderson & Mourning — ADDRESS 1502

EXAMINED — JOHN JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52464

E 52464

E 52464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 E 52464

1-PLACE OF DEATH

City of Baltimore: (No.) University Hospital St. 9-17 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ann Smith

(a) RESIDENCE NO. 1418 E. Oliver St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year) Sept. 28-1878.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
51	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER George Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mrs. John Smith
(Address) 1418 E. Oliver St.

15 Filed DEC 30 1929 H. [illegible] JONES [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar Fillers, M. D.

12-28 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	12/31 1929
UNDERTAKER George Ruth	ADDRESS 1730 Eastern Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 52465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Evergreen Ave. St.; Hamilton WARD)

2-FULL NAME Mary Augusta Dady

(a) RESIDENCE. No. 2701 Evergreen Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John L. Dady

6 DATE OF BIRTH (month, day, and year) Aug 29th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mc Namara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. J. Dady
(Address) 2701 Evergreen Av.

15 Filed DEC 30 1929 19 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1929 to Dec 28 1929, that I last saw her alive on Dec 27 1929, and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease cuntracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnusis? Symptoms

(Signed) Stanley E. Long, M. D.

Address 5631 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	12/30 1929

20 UNDERTAKER ADDRESS

E. D. Fanning 1936 E. Lafayette Ave

DEC 30 1929

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52466

CERTIFICATE OF DEATH

170 ✓

E 52466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2116 Pratt St. St., 1-3 Ward)

2-FULL NAME Charles L. Dawson

(a) RESIDENCE NO. 2116 Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 7 mos. 22 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Estelle C. Dawson

6 DATE OF BIRTH (month, day, and year) May 5 - 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Benjamin Bartlett Co

9 BIRTHPLACE (city or town) Bath, Md
(State or country)

PARENTS

10 NAME OF FATHER Edward H. Dawson

11 BIRTHPLACE OF FATHER (city or town) Washington D.C
(State or country)

12 MAIDEN NAME OF MOTHER Lucie Flott

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C
(State or country)

14 Informant Eunice Dawson
(Address) 2116 N. Pratt St

15 Filed ....., 19.. C. HAMILTON JONES, M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Interval unknown

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Boorde M. D.

12-28, 19 29 (Address) 3604 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL 12/30/ 19 29

20 UNDERTAKER F. H. Wyglusiti — ADDRESS 1105 N. Eutaw St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52467

E 52467

CERTIFICATE OF DEATH.

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 N Rose St. ST. 6-10 WARD)

2-FULL NAME Dolores B. Lytz

(a) RESIDENCE No. 440 N. Rose St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	X	3	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Lytz

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Caputo

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Lillian Lytz
(Address) 440 N. Rose St

15 Filed DEC 30 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/29/1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Infection
(Battle Fed)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Congenital Heart

(duration) yrs. mos. ds.

(Signed) J. S. Hoffman, M. D.
(Coroner.)

12/29, 1929 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 12/30 1929

20 UNDERTAKER J. T. Rinck

ADDRESS 1405 Light

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52468 + 9 E 52468

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 26-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Shyote

(a) RESIDENCE NO. Rosemount, Md. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. and

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John W. Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Laura Fox.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Connecticut

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed DEC 30 1929, 19 [illegible] Registrar

DEC 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 1929.

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1929 19 , to Dec. 26 , 1929, that I last saw h ex alive on Dec. 26 , 1929 and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic and acute

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. in Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Dec. 30th 1929

20 UNDERTAKER A. Jones

ADDRESS 1115 S. Gilmor

IMPORTANT—CERTIFICATE OF DEATH is in part legal, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 52469

E 52469

CERTIFICATE OF DEATH

Lancaster

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 633 N. Bond St., 7-9 Ward)

2-FULL NAME Bessie Green Lancaster

(a) RESIDENCE NO. 633 N. Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo. P. Lancaster

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) A.A.CO., Md.

PARENTS

10 NAME OF FATHER Richard Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Gray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant George P. Lancaster
(Address) 633 N. Bond St.

15 Filed DEC 30 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Lenetic)

(Note secother side)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Porter, M. D.

12/30/29 (Address) 306 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem Mail	12/30/29
20 UNDERTAKER	ADDRESS
Byron Wright	1218 N. Eden

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Any information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52470 E 52470

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1-602

CITY OF BALTIMORE: (No. 607 Woodington Ave. ST. 28-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rev. F. A. Heilman, D.D.

(a) RESIDENCE NO. 607 Woodington Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara P? Heilman,

6 DATE OF BIRTH (month, day, and year) August 23 .18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Daniel Heilman,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs Barbara P Heilman

(Address) 607 Woodington Ave

15 Filed DEC 30 1929, 19 H. M. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929 to Dec 28, 1929

that I last saw h[illegible] alive on Dec 28, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH was as follows:

Intestinal Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Heart failure a. Dilatation of Heart 10 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Byers, M. D.

12.30 1929 (Address) 616 WOODINGTON AVE.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL DEC 31, 1929

20 UNDERTAKER Robert S Little

ADDRESS 2708 EDMONDSON AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52471

CERTIFICATE OF DEATH.

88-203

E 52471

REGISTERED NO.

1-PLACE OF DEATH Md General Hospital

City of BALTIMORE: (No. Madison & Linden Ave. Ward) 13-57

2-FULL NAME Frank B. Hottinger

(a) RESIDENCE NO. 3636 Buena Vista Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ada E. Hottinger

6 DATE OF BIRTH (month, day, and year): Dec 29/1864

7 AGE: Years 64. Months 11. Days 29. If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Harrisonburg

(State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Ada E. Hottinger Wife

(Address): 3636 Buena Vista ave

15 Filed ..... 19 .....

Registrar

C 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/28/1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Fract Petrus portion Temporal Bone R Run down by automobile ac

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sub Dural Heamorrhage

(duration) ..... yrs. ..... mos. ..... ds.

12/29/1929 (Signed) J. J. Fraine M. D.

(Coroner)

(Address) 29 Squire Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Emory Road No Buckles Lane Balto Co

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's P.E. Cem Hunt Date of Burial 12/31/1929

20 UNDERTAKER: Walter Davis ADDRESS 330 E. Lanvale St.

C OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 / E 52472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. S. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Blum

(a) RESIDENCE NO. 15 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Lena Blum

6 DATE OF BIRTH (month, day and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Baltimore St.

15 Filed DEC 30 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29 19 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 19 29, to Dec. 29, 19 29, that I last saw him alive on Dec 29, 19 29, and that death occurred, on the date stated above, at 11.10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Hamburger M. D.

12/30 19 29 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rowdale

DATE OF BURIAL 12/30 19 29

20 UNDERTAKER Jack Lewis 1439 E Baltimore St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52473

CERTIFICATE OF DEATH

90 E 52473

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Barclay ST. 17-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecelia Thompson

(a) RESIDENCE NO. 3409 Barclay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C. Johnson Thompson

(Address) 3409 Barclay St

15 Filed 30 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 1929, to Dec 26 1929, that I last saw alive on Dec 26 1929, and that death occurred, on the date stated above, at 7-45A m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec 30, 1929 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Dec 30 29

20 UNDERTAKER Samuel Wensley ADDRESS 1534 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C

Spec.—2-29-28—L. F. S.—500 Bks.

E 52474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 52474

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3718 Gough St. ST. 46-37 WARD)

2—FULL NAME James Szymanski

(a) RESIDENCE NO. 3718 Gough ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm Szymanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Maczenska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Wm Szymanski

(Address) 3718 Gough str

15 Filed ..... 19 ..... Registrar

C 30 1929 BAMPSON PRINTS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29-1929

17

I HEREBY CERTIFY, That I attended deceased from December 25, 1929, to Dec 29, 1929

that I last saw him alive on Dec. 29, 1929

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Lewonski, M. D.

12/29 1929 (Address) 716 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 12/31 1929

20 UNDERTAKER Wm. Siayfowski — ADDRESS 1618 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52475 — 1-PLACE OF DEATH

City of Baltimore: (No. Franklin Eye Hosp. 16-37 Ward)

E 52475 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kalaman

(a) RESIDENCE NO. 4915 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kalaman

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Sherman Pa

PARENTS

10 NAME OF FATHER John Kalaman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sherman Pa

12 MAIDEN NAME OF MOTHER Anna Pusias

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Sherman Pa

14 Informant Mary Kalaman
(Address) 4915 Eastern Ave

15 Filed ..., 19.. ..., Registrar

DEC 30 1929 THOMPSON

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Brooks, M. D.

12/29, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sherman Pa — DATE OF BURIAL 12/31 1929

20 UNDERTAKER Robert Brooks & Son — ADDRESS Baltimore

Spec.—1-10-21—M&T—1500 Blks.

E 52476 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52476

CERTIFICATE OF DEATH.

REGISTERED NO. 139

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Caroline & Dust 15-21 ST., (or) WARD

2-FULL NAME Mary Barclay

(a) RESIDENCE NO. 1420 Bruce ST., (or) WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Webster Barclay

6 DATE OF BIRTH (month, day, and year) Feb 25, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwards Robinson

11 BIRTHPLACE OF FATHER (city or town) Phila. (State or country) Pa.

12 MAIDEN NAME OF MOTHER Katie Walker

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Elizabeth Thomas (Address) 902 W Franklin St

15 Filed DEC 30 1929 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-24-29, 19 , to 12-26-29, 19 , that I last saw h alive on 12-26-29, 19 , and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Fibroid Uterus with Intestinal obstruction

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) acute cardiac dil (duration) 3 hrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12/24/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A M Handley M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec 30, 1929

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 332 N Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

52477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 52477

1—PLACE OF DEATH 228 N. Payson St.

REGISTERED NO.

CITY OF BALTIMORE: (No. 20-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E. Jones

(a) RESIDENCE NO. 228 N. Payson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie H. Jones

6 DATE OF BIRTH (month, day, and year) Nov. 25th 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Metamora Indiana

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Sophie Vance

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Katie H. Jones

(Address) 228 N. Payson St

15 Filed DEC 30 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 28, 1929, that I last saw h~~im~~ alive on Dec 27, 1929 and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Artero sclerosis

(duration) 2-3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bamberger M. D.

12/28, 1929 (Address) 622 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec 31st 1929

20 UNDERTAKER Charles W. Dill

ADDRESS 5109 Frankford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 52478

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1622 Church Carly Bay 5th Ward

Registered No.

2-FULL NAME Rosalia Demczynska Alexandrowicz (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1622 Church St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carol Demczynski

6-DATE OF BIRTH (month, day and year) May 2-1860

7-AGE. 69 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Andrew Dymowski

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Frances ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Poland

11- (Informant) Stanley Russel (Address) 1622 Church St.

15- Filed DEC 30 1929 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 27-1929

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1929 to Dec 30 1929 that I last saw h[illegible] alive on Dec 28 1929 and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon P. Horka M. D.

Dec 27, 1929 (Address) 470 Pleasington Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL. 12/31 1929

20-UNDERTAKER. F. W. Ozagowski

ADDRESS 193 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52479

CERTIFICATE OF DEATH

101-001 V

E 52479

1-PLACE OF DEATH

City of Baltimore: (No. Cherry Hill, Westport. St. 25-32 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert W. Kaiser.

(a) RESIDENCE NO. Cherry Hill Westport. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 21, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John J. Kaiser.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Grace U. Hohlbein.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant John J. Kaiser. (father)
(Address) Cherry Hill, Westport.

15 Filed ..... 19.. THOMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Inquiry

(Signed) Nicholas Leonardi, M. D.

2/30. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Dec 31 1929
20 UNDERTAKER C. Schlosman & Son	ADDRESS 1039 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 30 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52480 ✓ E 52130

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1034 W. Lexington St. (ST.) 18-21a (WARD)

2-FULL NAME Anna Elizabeth Dorsey

(a) RESIDENCE NO. 1034 W. Lexington St. (ST.) ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Henry Dorsey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Abt.	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

087

9 BIRTHPLACE (city or town) (State or country) Howard Co., Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Dorsey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Lewis S. Crawford (Son)
(Address) 1034 W. Lexington St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

C 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28th 19 29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7th. , 1929 , to Dec 28th , 19 29

that I last saw h e alive on Dec 27th. 1929

and that death occurred, on the date stated above, at 8;50 A. m

The CAUSE OF DEATH* was as follows:

Mitral Ins. Ch. Int Nephritis.

..... (duration) yrs. ..... mos 28 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... At place of death

Did an operation precede death? ..... Date of .....

Was there an autopsy? ..... No.

What test confirmed diagnosis? ..... Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Howard Co and Dairy Cem — DATE OF BURIAL: Dec 31 1929

20 UNDERTAKER: Joseph A Lively — ADDRESS: 704 N Mount St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52481

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 52481

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No.) Balto Md (ST.) 16-37 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T Barber

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) Balto City Hosp

15 Filed ..... 19 .....

1330 HAMPSON JONES, M.D.
Per ..... Registrar

DEC 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26-29

17 I HEREBY CERTIFY, That I attended deceased from 11-21-, 1929, to 12-26-, 1929, that I last saw him alive on 12-26-, 1929, and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lung Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Surgical & Clinical

(Signed) Harry Goldman, M. D.

12-27, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Removed by Undertaker	DEC 30 1929
JOHNS HOPKINS HOSPITAL	Dec 30 1929
BALTIMORE CITY DEPARTMENT OF HEALTH	
20 UNDERTAKER. I intend to use the Ambulance Car	ADDRESS
Harold Epstein	916 Penna Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52482

CERTIFICATE OF DEATH

X 1/3

E 52482

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Greenland + Green St. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosalie Miser

(a) RESIDENCE NO. Oakland Md ST., WARD A A Co, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1929

7 AGE: Years — Months 2 — Days 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Ralph Miser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Lillian Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant

(Address)

15 Filed DEC 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Dec 24, 1929, that I last saw h alive on Dec 24, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis, acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematur

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

Dec. 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: DEC 30 1929

20 UNDERTAKER: City Commissioner Health.

ADDRESS

DEC 30 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

E 52483 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 511 W. Cross (ST.) 21-31 (WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gumby Barclay

(a) RESIDENCE NO. 511 W. Cross ST., WARD Salisbury Md
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Barclay

6 DATE OF BIRTH (month, day, and year): 7 1889

7 AGE: Years 48 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Days Work

(b) General nature of industry, business, or establishment in which employed (or employer): in mit side

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Salisbury, Wicomico Co Md

PARENTS

10 NAME OF FATHER: Benjamin Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Princess Anne Maryland

12 MAIDEN NAME OF MOTHER: Tamer Pollett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co Maryland

14 Informant: George Gumby
(Address): Salisbury Md

15 Filed C 30 1929 19 H. THOMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/18, 1929, to 12/25, 1929, that I last saw her alive on 12/25, 1929, and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Nephritis

(duration) Chr yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D.M. Vansant M. D.

(Address) 12 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury Md — DATE OF BURIAL: Dec 31 1929

20 UNDERTAKER: S. L. Brown & Son — ADDRESS: 108 W Main St

154 Boat St Pier 5

Reg. 5.—WRITE PLAINLY, with unfading ink. This certificate, when completed, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52484

E 52484

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH Maryland General Hospital — REGISTERED NO.

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Buodynski

(a) RESIDENCE NO. 2121 Eastern Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Buodynski

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 41 Months Days IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: John Rasinski

11 BIRTHPLACE OF FATHER (City or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Rasinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Hospital Records

15 Filed ____ 19 ____ WILLIAMSON JONES, M. D. Registrar

DEC 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/29 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/29, 1929, to 12/29, 1929, that I last saw h[illegible] alive on 12/29, 1929, and that death occurred, on the date stated above, at 11:25 P.m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary): Cerebral embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem — Date of Burial: Jan 2 1930

20 UNDERTAKER: John M Weber — ADDRESS: 4010 Chester

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52485

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Aliceanna St. ST. 3-4 WARD)

2-FULL NAME Maryanna Juras Or Polek

(a) RESIDENCE NO. 1514 Aliceanna St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	62	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Agnes Szymborski
(Address) 1514 Aliceanna St.

15 DEC 30 1929 C. HAMPSON JONES, M. D. Registrar
By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929 to Dec 28, 1929
that I last saw him alive on Dec 28, 1929
and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William L. Rydzewski M. D.
Dec 29 1929 (Address) 801 S Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. | DATE OF BURIAL Dec. 31 1929

20 UNDERTAKER John M. Weber | ADDRESS 40 S. Chester St

C.S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

De Marco

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52486

CERTIFICATE OF DEATH

89

E 52486

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1603 Linden Ave ST.) (WARD) 14-70

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. Cooney

(a) RESIDENCE NO. 1603 Linden Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Cooney.

6 DATE OF BIRTH (month, day, and year) aug 8. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	70	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer J. G Brill Co

9 BIRTHPLACE (city or town) Philadelphia (State or country) Penna

PARENTS

10 NAME OF FATHER James Cooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Isabelle Gurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary V. McGowan

(Address) 1603 Linden ave

15 Date DEC 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-27-, 1929, to 12-29, 1929

that I last saw h.. alive on 12-29, 1929

and that death occurred, on the date stated above, at 2.15 p m.

The CAUSE OF DEATH* was as follows:

Angina pectoris -

(duration) ?, yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris Coronary Thrombosis - (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. D Spencer, M. D.

12-29-1929 (Address) Medical arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Jan 3 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CA... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION i... important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(Letra)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52487

CERTIFICATE OF DEATH

111-01 E 52487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hosp' St., 3-5 Ward)

2-FULL NAME Lucia Litra

(a) RESIDENCE NO. 242 S. Eden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE: Years 43 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Artist
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town): Italy
(State or country)

PARENTS

10 NAME OF FATHER: Joseph Valeri

11 BIRTHPLACE OF FATHER (city or town): Italy
(State or country)

12 MAIDEN NAME OF MOTHER: Lucy Valeri

13 BIRTHPLACE OF MOTHER (city or town): Italy
(State or country)

14 Informant: Paul Litra
(Address) 242 S. Eden

15 Filed ..... 19 .....
C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Ulcer Stomach.

Admitted in hosp. abt 14 Days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? Cornal

What test confirmed diagnosis? —

(Signed) W. J. Kelly M.D. Coroner

Dec 30 1929 (Address) 1639 Bradway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. | DATE OF BURIAL: Dec 31, 1929

20 UNDERTAKER: Heidell J Appel | ADDRESS: 300 E Eden

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. 30 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52488

CERTIFICATE OF DEATH

74-801 V E 52488

1—PLACE OF DEATH

REGISTERED NO. 1357

CITY OF BALTIMORE: (No. 4232 Falls Road ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma E. Abbott

(a) RESIDENCE NO. 4232 Falls Road ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): — 1859

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Francis Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nellie Tickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Frank L. Abbott

(Address): 4232 Falls Road

15 FILED [illegible] 19 [illegible] C. HAMPSON JONES, M. D. Registrar

DEC 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 29-1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19 29. to Dec 29, 19 29, that I last saw her alive on Dec 27, 19 29 and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexia - R. Hemiplegia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

12/30 19 29 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: Dec. 31 19 29.

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 3631 Falls Road

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 52489

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4514 Schenley Road ST., WARD)

2—FULL NAME Anna Rosella Allison

(a) RESIDENCE NO. 4514 Schenley Road ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 10 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced RUSBAND of (or) WIFE of John J. Allison

6 DATE OF BIRTH (month, day, and year) Feb. 26-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John L. Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J. Akehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant Mrs. Lee D. Johnson

(Address) 4514 Schenley Road

15 Filed DEC 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30-1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to December 30, 1929, that I last saw h[illegible] alive on December 29, 1929 and that death occurred, on the date stated above, at 1[illegible]5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) [illegible], M. D.

12-30, 1929 (Address) 3427 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan. 1 1930

20 UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should st[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA[illegible] is very important. See instructions on back of certificates.

DEC 30 1929

Spec.—2-29-28—L. F. S.—500 Bks.

SPRAGUE

100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52490

CERTIFICATE OF DEATH

E 52490

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. 33rd & Calvert Sts. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Sprague

(a) RESIDENCE NO. 3817 Roland ave ST. 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs John H. Sprague.

6 DATE OF BIRTH (month, day, and year) June 12, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	59	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 63

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Government

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Raymond Sprague

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rhode Island

12 MAIDEN NAME OF MOTHER Carrie Duke.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rhode Island

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... JAMESON JONES, M. D. Registrar

C 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29-1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Dec 29, 1929, that I last saw h.im alive on Dec. 29, 1929 and that death occurred, on the date stated above, at 6:50A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3817 Roland ave.

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical examination

(Signed) Francis W. Gluck, M. D.

. 19 (Address) Union memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N. Mary's (Hampden)	Jan. 1-1930.
20 UNDERTAKER	ADDRESS
H. Horace H. Burgue	363 Fall Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52491

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. 125-10 ST. Lemo WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James Rosensteel

(a) RESIDENCE NO. Emmitsburg Md, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	75	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Rosensteel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records (Address)

Filed DEC 31 1929 G. HALL JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 30, 1929, that I last saw him alive on Dec 30, 1929, and that death occurred, on the date stated above, at 11.20 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) gangrene of foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Md

DATE OF BURIAL Dec 31 1929

20 UNDERTAKER M. F. Shuff Jr

ADDRESS Emmitsburg Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52492

CERTIFICATE OF DEATH

129 E 52492

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Clifton Ave ST., 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederica H. Werner

(a) RESIDENCE NO. 1803 Clifton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

a If married, widowed, or divorced HUSBAND of (or) WIFE of August C. Werner

6 DATE OF BIRTH (month, day, and year) Sept 11, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick H. Streithagen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hanna Bleeding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Claire Lydia Weber

(Address) 1803 Clifton Ave.

15 Filed DEC 31 1929, H. M. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1929

17

I HEREBY CERTIFY, That I attended deceased from 12-1, 1927, to 12/29, 1929, that I last saw h[illegible] alive on 12/27, 1929, and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) [illegible], M. D.

12/30, 1929 (Address) 1925 Linden Ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec 31, 1929
20 UNDERTAKER Wm J. Pickuer & Sons	ADDRESS North & Paca

Nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 52493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 ✓

E 52493

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3303 Carlisle Ave St.: 15-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Catherine T Throop

(Residence in Baltimore: No. 3303 Carlisle Ave. St.; 1 yrs., 3 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: Sept 30, 1848 (Month) (Day) (Year)

7-AGE: 81 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Mt. Vernon Indiana

PARENTS.

10-NAME OF FATHER: Morris Fuhrer

11-BIRTHPLACE OF FATHER (State or Country): Switzerland

12-MAIDEN NAME OF MOTHER: Angelyn Nelson

13-BIRTHPLACE OF MOTHER (State or Country): Mt Vernon Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank D. Throop

(Address) 3303 Carlisle Ave

15-

Filed Dec 31 1929 C. H. [illegible] JONES, M. D. Registrar.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29, 1929 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1929, to Dec 29 1929, that I saw her alive on Dec 29 1929, and that death occurred, on the date stated above, at 11.53 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) 3 yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 30, 1929 (Address) 2160 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Evansville Ind

DATE OF BURIAL: Dec 31, 1929

20-UNDERTAKER: Wm J Pickney Sons

ADDRESS: N. York Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52494 100-001 E 52494

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 27-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Thrush

(a) RESIDENCE NO. 522 S Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city, town or county where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 5, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Hosp. Records. (Address) Balto. City Hosp.

15 Filed C. H. JAMESON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 12-27, 1929, to 12-30, 1929, that I last saw him alive on 12-30, 1929 and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan 1 1930
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 1002 E 52495

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Battery Ave., ST. 24-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William C. Van Nostrand

(a) RESIDENCE NO. 1517 Battery Ave., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie B. Van Nostrand

6 DATE OF BIRTH (month, day, and year) July 9, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	19. 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER William A. Van Mostrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Sallie B. VanNostrand

(Address) 1517 Battery Ave.

15 Filed DEC 31 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 22, 1929 to December 28 1929

that I last saw him alive on December 28 1929

and that death occurred, on the date stated above, at 3'30 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw V Cronlaburn M. D.

12/30 29 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: 12/31 1929

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 ✓ E 52496

REGISTERED NO. 11-24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 672 Orford ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Johnson

(a) RESIDENCE NO. 432 N Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida D Johnson

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Del

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida F Johnson

(Address) 432 N Biddle St

15 Filed DEC 31 1928 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 - 1929, to Dec 28 - 1929, that I last saw h[illegible] alive on Dec 28, 1929 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of Oct. 1929

Was there an autopsy? No.

What test confirmed diagnosis? Phys exam.

(Signed) Chas. J. Keller, M. D.

12/30. 1929 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 12/31 1929

20 UNDERTAKER Samuel D Kemsley — ADDRESS 578 N Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 99-002 E 52497

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eden Sts ST. 9-17 WARD)

2-FULL NAME Charles Walker

(a) RESIDENCE NO. Anne Arundel Co., Maryland WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2nd yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ida Ellis
(Address) 732 Hollins St

15 Filed DEC 31 1929 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-4 .1929. to 12-28 .1929.

that I last saw h alive on 12-28 .1929.

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Bilateral Hypostatic Pneumonia

(duration) yrs. mos 8 days

CONTRIBUTORY (Secondary) Stricture of urethral Bronchitis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At St. Joseph Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M B Hardesty, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy — DATE OF BURIAL 12.31 1929

20 UNDERTAKER John H. Trading — ADDRESS 1027 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.— . F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52498

CERTIFICATE OF DEATH

134 001 E 52498

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 12-50 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles C. Brown

(a) RESIDENCE NO. 235? N Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
?	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Wm R. Brown

11 BIRTHPLACE OF FATHER (city or town) Penna. Pa
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Langston

13 BIRTHPLACE OF MOTHER (city or town) ? Md
(State or country)

14 Informant Hospital Records
(Address)

15 Filed DEC 31 1929, 19 H. M. ROBERTS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929, to Dec. 29, 1929, that I last saw him alive on Dec. 29, 1929, and that death occurred, on the date stated above, at 1:12 a.m.

The CAUSE OF DEATH* was as follows:

Stricture of prostatic urethra producing bladder retention, complete suppression

CONTRIBUTORY (Secondary) ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M. Paulin Bird, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 12/31 1929

20 UNDERTAKER W. Cook — ADDRESS 1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52499

CERTIFICATE OF DEATH

E 52499

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 ~~Elsinore~~ Elsinore ave ST., 44 WARD)

REGISTERED NO. 101001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James B. Garick Garrick

(a) RESIDENCE NO. 3002 Elsinore ave ST., 1-14-29 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Garick

6 DATE OF BIRTH (month, day, and year) Nov 5. 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43.	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Lime Product

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Ambrose Garick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Ellen Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Gertrude Garick.

(Address) 3102. Elsinore ave.

15 Filed DEC 31 1929 Registrar

WILLIAM J. JONES, M.D.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Dec. 28-1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Dec. 28, 1929, that I last saw ~~him~~ alive on Dec 27, 1929 and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Prentiss, M. D.

. 19 (Address) 634 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County.	Dec 31 1929
20 UNDERTAKER	ADDRESS
George J. Ruth.	1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52500

118-002

CERTIFICATE OF DEATH

E 52500

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE, (No. 1604 N Calhoun St. WARD) 15-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Lula Braxton

(a) RESIDENCE NO. 1604 N. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Braxton.

6 DATE OF BIRTH (month, day, and year): Mar. 26, 1902

7 AGE — Years: 27 | Months: 9. | Days: 3. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Willis Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Florance Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Florance Giles

(Address): 1604 N. Calhoun St.

15 Filed: DEC 31 1929 Registrar: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/29/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 29, 1929, that I last saw her alive on Dec 29, 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Staehle, M. D.

12/31, 1929 (Address) 1111 Park Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery

DATE OF BURIAL: Jan 1 1930

20 UNDERTAKER: Thomas E Nelson

ADDRESS: 130 Preston St

Nation shall be written in full, so that if may be proper; OF DEATH in plain terms, so that it may be proper; important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 52501

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (WARD) 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leona Powell

(a) RESIDENCE NO. 1326 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 31 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	11 10	27 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Waverly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 31 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 27, 1929, that I last saw her alive on Dec 27, 1929 and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Miliary tbc, tuberculosis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Acid fast bacilli in fluid from spinal

(Signed) T. B. Y. Warren, M. D.

12/29/1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 31, 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pierstman St

match should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 31 ✓ E 52502

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elijah Green

(a) RESIDENCE NO. Brooklyn, Md R 4 D 4th ST., C.T.B.M. WARD Patapsco Park, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Green

6 DATE OF BIRTH (month, day, and year) No data

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Team Driver

(b) General nature of industry, business, or establishment in which employed (or employer) no data 0 23

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Moses Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Baltimore City Hosp. (Address) Eastern Ave & H...

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Dec 28, 1929, that I last saw him alive on Dec 27, 1929 and that death occurred, on the date stated above, at 3 40 P.m.

The CAUSE OF DEATH* was as follows:

Pulmn Tuberculosis

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None

— (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) Jos J Arnold Jr, M. D.

, 19 (Address) Balt City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Dec. 31 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland Ave

DEC 31 1929

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 ✓ E 52503

1—PLACE OF DEATH Baltimore City Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Saunders

(a) RESIDENCE NO. 238 S Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Unknown~~ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Baltimore City Hospitals
(Address) Broadway

15 Filed DEC 31 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27-29

17 I HEREBY CERTIFY, That I attended deceased from 12-13- , 1929, to 12-27, 1929, that I last saw h~~im~~ alive on 12-27-29, 19 and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Upper Jaw

(duration) ~~Unknown~~ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) —yrs. —mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Fred M. Buckwalter, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	June 2 1930

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Eastlandway

2. Be—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52504

CERTIFICATE OF DEATH.

118-E 52504

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Monument & Rutland ST. 5-8 WARD)

2-FULL NAME Jacob Schroeder

(a) RESIDENCE NO. 132 Azgunth H. ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life 50 yrs. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Schroeder

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or, min.
54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney and

(b) General nature of industry, business, or establishment in which employed (or employ Judge Northern

(c) Name of employer Belle Slatiar

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Aaron Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Celia Rosenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ada Schroeder
(Address) 132 Garrison Blvd

15 Filed DEC 31 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 12/30 1929.

17 I HEREBY CERTIFY, That I attended deceased from 12/25 1929 to 12/30 1929.

that I last saw h. alive on 12/30 1929.

and that death occurred, on the date stated above, at 4 35 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Toxemia Cardiac failure (duration) yrs. mos. 2 ds. 1 day

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 12/26/29 12/25/29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Eudeman M. D.

19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Blvd Jan 1 1930

DATE OF BURIAL

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52505

CERTIFICATE OF DEATH

89 ✓ E 52505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N. Stricker ST. 14-27 WARD)

2—FULL NAME Harris Feldman

(a) RESIDENCE NO. 300 N. Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bella Feldman

6 DATE OF BIRTH (month, day, and year): May 10-1865

7 AGE: Years 63 | Months 4 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis
(Address): 1439 E. Balto St

15 Filed DEC 31 1929 19 H. [illegible] JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 30-29

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 27, to Dec. 30, 19 29, that I last saw h[illegible] alive on Dec. 30, 19 29 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor L Levy, M. D.

Dec. 19 29 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle, Hebrew Mt. Carmel

DATE OF BURIAL: 12-31-1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52506

CERTIFICATE OF DEATH

129 E 52506

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 E. 41st ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonora Keys Johnson

(a) RESIDENCE NO. 605 E. 41st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fayette Johnson

6 DATE OF BIRTH (month, day, and year): Dec. 17-1846

7 AGE: Years 83 | Months - | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Joseph T. Keys.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Ruth M. Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: Lucille A. Maguire

(Address) 605 E. 41st St. Johns, Md.

15 Filed DEC 31 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 30-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1925 to Dec. 30- 1929, that I last saw her alive on Dec. 29- 1929 and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) 12-30-29 H. C. Keys., M. D.

12-30 1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: Jan. 1 1930

20 UNDERTAKER: George W. Zinkler

ADDRESS: 1737 E. Eager st

Spec.—8-16-29—L. F. S.—100 Blks.

E 52507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr Richardson 12 E 25th St

74 E 52507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Greenmount ave ST., 9-46 WARD)

2—FULL NAME George Ruppert

(a) RESIDENCE NO. 2911 Greenmount ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle D. Ruppert

6 DATE OF BIRTH (month, day, and year) Aug. 31-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Prudential Ins. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Ruppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Winfelder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Myrtle D. Ruppert

(Address) 2911 Greenmount ave

15 Filed DEC 31 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 11 1929 to Dec 29 1929

that I last saw h. alive on Dec. 29 1929

and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hem.

Diabetes (duration) yrs. months ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

Dec 31. 1929 (Address) 1172 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan 2 1930
20 UNDERTAKER	ADDRESS
George W Zitken	1737 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52508

CERTIFICATE OF DEATH

90 ✓

E 52508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1825 N. Broadway St., 8-17 Ward)

2-FULL NAME WILLIAM HENRY WOOD

(a) RESIDENCE NO. 1825 N. Broadway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) November 8, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Dock Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 12 years

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John D. Wood

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A. Parker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Miss Mary A. Wood (Sister)

(Address) 1825 N. Broadway

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis- Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prostatectomy 6 wks ago

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 6 wks ago

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Bacon, M. D.

12/30/29 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetary — DATE OF BURIAL: Dec. 31 19 29

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: Baltimore & Broadway

DEC 31 1929

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52509

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52509

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 2-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Svend Petersen

(a) RESIDENCE NO. Anchorage Hotel, S. Broadway Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) December 25,1907

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	22	0	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Denmark

PARENTS

10 NAME OF FATHER Svend Petersen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Denmark

12 MAIDEN NAME OF MOTHER Christine Frost

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Denmark

14 Informant Mr. Hans Frost (Uncle)
(Address) 504 S. Belnord Ave.

DEC 31 1929

Filed [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 30, 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Bilateral
Meningitis (Pneococcic)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/30/29 (Address) 500 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Paul's Cemetery	Dec. 31 19 29

20 UNDERTAKER Henry Sander & Sons. Inc. ADDRESS Baltimore & Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52510

CERTIFICATE OF DEATH

E 52510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 910 Peach Alley. 22-31 Ward)

2-FULL NAME Annie Wesley.(C)

(a) RESIDENCE NO. 881 Leadenhall St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If ~~MARRIED~~, widowed, ~~DIVORCED~~ (or) WIFE of Herman Wesley.(C)

6 DATE OF BIRTH (month, day, and year) November 15, 1908

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	21	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) A.A.Co.Md.
(State or country)

PARENTS

10 NAME OF FATHER Sheppard Mills (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Elizabeth Watkins(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina.

14 Informant Elizabeth Mills.(C)mother.
(Address) 881 Leadenhall St.

15 Filed ..., 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 26, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) ..., M. D.

12/29/29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec 31, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 3221 Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

E 52511

REGISTERED NO. E 52511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3053 Guilford ave ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Stanbury Evans

(a) RESIDENCE NO. 3053 Guilford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Evans

6 DATE OF BIRTH (month, day, and year) Sept. 12th 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. Evans

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Worrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Kate A. Grove (Address) 1233 Harford Ave.

15 Filed DEC 1 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 19 29, to Dec 29 1929, that I last saw h. alive on Dec 29, 1929 and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sidney Hart M. D.

, 19 (Address) 210 Lexington Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan. 1, 1929
20 UNDERTAKER	ADDRESS
Frederick Lanahan	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Blks.

23 2505

E 52512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100 001 E 52512

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy Brown

(a) RESIDENCE NO. 135 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER Arthur Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S—C—

12 MAIDEN NAME OF MOTHER Gladys Newell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S—C—

14 Informant Records

(Address)

15 Filed DEC 31 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29/29

17 I HEREBY CERTIFY, That I attended deceased from December 24, 1929, to December 29, 1929, that I last saw h/ alive on December 29, 1929 and that death occurred, on the date stated above, at 4 40 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Acute otitis media

Sinus thrombosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

12/31/1929 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemet.	Dec 31 1929
20 UNDERTAKER	ADDRESS
Mrs R a Elliott	1725 ashland ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52513

100-001

E 52513

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital

REGISTERED NO. 17-51

CITY OF BALTIMORE: (No. 1514 Division ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Washington

(a) RESIDENCE NO. 2119 Oak ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Dead

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed DEC 31 1929 4218 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29-29

17

I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 29, 1929, that I last saw h.im alive on Dec 29, 1929 and that death occurred, on the date stated above, at 8 42 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

12/29, 1929. (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 31 1929 19

20 UNDERTAKER Commissioner Health

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52514

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4-001
E 52514

1—PLACE OF DEATH

REGISTERED NO. 2455

CITY OF BALTIMORE: (No.) Pk. Hgts + Slade ST. 24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David L. Greif

(a) RESIDENCE NO. Pk. Hgts + Slade Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Stella W. Greif

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Mnfgr. 045

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Leiv Greif

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bennie Hirshman

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Alvin Greif
(Address) Slade Ave

DEC 31 1929

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 19 29, to Dec 30, 19 29, that I last saw him alive on Dec 30, 19 29 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ✓ yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Ernest E. Wagner, M. D.

12/30, 19 29 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	1/1/1930

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52515

CERTIFICATE OF DEATH

E 52515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sugar Refinery Wharf Curtis Bay St., (Ward) 25-11

2-FULL NAME Frans Valdemar Berlin.

(a) RESIDENCE NO. Tygelsjo, 186. Malmo, Sweden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 19, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	0	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal trimmer S/S Kai.
(b) General nature of industry, business, or establishment in which employed (or employer) 674
(c) Name of employer

9 BIRTHPLACE (city or town) Sweden.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Jorden White, Vice Consul Sweden.
(Address) Pier No. 5 Pratt St.

15 Filed ..... 19..... [illegible] JONES, M. D. Registrar

DEC 31 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Drowned Dec. 28, found December 28, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a wharf.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

12/31 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & E	12-30 1929
20 UNDERTAKER Bernard C Hardiman	ADDRESS 1 Pace St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52516

CERTIFICATE OF DEATH

44 E 52516

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1826 W Fort Ave ST., 15-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Virginia Scott

(a) RESIDENCE NO. 1826 W Fort Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W Scott

6 DATE OF BIRTH (month, day, and year): May 25 1868

7 AGE: Years 61 | Months 7 9 | Days 05 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Portsmouth Va

PARENTS

10 NAME OF FATHER: Isaac Layden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Jane Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Geo W Scott

(Address): 1826 W Fort Ave

15 Filed DEC 31 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from — , 1927, to 12-30 , 1929,

that I last saw h.er alive on 12-29 , 1929

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. E. Wiesin , M. D.

, 19 (Address) 1400 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery | DATE OF BURIAL: Jan 2 1930

20 UNDERTAKER: Kertland & Fore | ADDRESS: 1728 N Lafayette Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

70 E 52517
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 5-8 WARD)

2-FULL NAME Hannah Spiklosen

(a) RESIDENCE NO. 1106 E Fayette ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE: Years 16 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Adolph Spiklosen

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Fanny Locks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Henry Spiklosen
(Address) 1106 E. Fayette St

15 Filed C. HARRISON JONES, M.D. Dec 31 1929
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1929 to Dec. 30, 1929.
that I last saw her alive on 12/30, 1929.
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
~~Cerebro spinal Fever.~~
Brain abscess - right side -
(occipital lobe)
(duration) yrs. 1 mos ds.

CONTRIBUTORY
(Secondary) Respiratory Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?

12/30 1929 (Signed) Benjamin Baker M. D.
(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL 12/31 1929

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 Eutaw St

DEC 31 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

52518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 52518

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Elrino ST. 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Henry

(a) RESIDENCE NO. 1517 Elrino ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Henry

6 DATE OF BIRTH (month, day, and year) April 22, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0 57

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Wildt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Henry Adams

(Address) 1517 Elrino St

15 Filed DEC 31 1929 C. HUNTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 30th 29 to Dec 30 - 29, that I last saw her alive on Dec 30 1929 and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Strangulation Intestine

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. D. Kruman, M. D.

12/31/29 (Address) 1913 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Jan 2 1929

20 UNDERTAKER John Welch

ADDRESS 2008 Aisquith

INFORMATION, WHICH CAN BE GIVEN BY PERSONS HAVING KNOWLEDGE OF THE FACTS, IS REQUIRED BY LAW. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 52519

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 ROslyn Ave. ST. 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ettie Ringgold Tolson

(a) RESIDENCE NO. 2202 Roslyn Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	WIDOW

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Tolson

6 DATE OF BIRTH (month, day, and year) Feby. 16, 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Thomas Ringgold

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John C. Tolson

(Address) 2202 Roslyn Ave.

15 Filed DEC 31 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29, 1929

17 I HEREBY CERTIFY That I attended deceased from Nov 30, 1929, to Dec 29, 1929, that I last saw h[er] alive on Dec 28, 1929 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Generalized arterio-sclerosis.
Cerebral Hemorrhage
(Nov 3, 1929).

(duration) yrs.

CONTRIBUTORY (Secondary) Ac. Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Carroll Lockard, M.D.

Dec 30, 1929 (Address) 4 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kent Island Cemetery	Jany. 1, 1930
20 UNDERTAKER John C. Mitchell & Sons	ADDRESS 1900 Eutaw Pla

Odie O. Mitchell

IMPORTANT, WITH CAUSE STATED AS DIRECTED, THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52520

CERTIFICATE OF DEATH

31

E 52520

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Mulliken ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James L. Johnson

(a) RESIDENCE NO. 1600 Mulliken ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Willie Johnson

(Address) 224 N Fallsway

15 Filed DEC 31 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 19 29 to Dec 30, 19 29, that I last saw h. alive on Dec 29, 19 29 and that death occurred, on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Young, M. D.

12/31, 19 29 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Suffer Va	Jan 3 1930
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52521

CERTIFICATE OF DEATH

90 E 52521

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wiley Best

(a) RESIDENCE NO. 1418 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Best

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Harry Best

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Lillie Best

(Address) 1418 McElderry St

15 Filed Jan 30 1930 Geo. Hiyyy Jones II Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30/29.

17

I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Dec 30, 1929, that I last saw him alive on Dec 30, 1929 and that death occurred, on the date stated above, at 12 05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertension Cardiovascular disease (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Assumed

(Signed) L. F. Jackson M. D.

1/30, 1929 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilson N. C	Jan 1 1930
20 UNDERTAKER Edward Bryan	ADDRESS 681 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 52522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 52522

1-PLACE OF DEATH

City of BALTIMORE: (No. 3642 Malden Ave St., 13-57 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Francis Albert Grolock.

(a) RESIDENCE NO. 3642 Malden Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Kezrah V. Grolock.

6 DATE OF BIRTH (month, day, and year) Nov-4-1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill hand oth

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton duck

(c) Name of employer Wm E. Hooper & Sons.

9 BIRTHPLACE (city or town) Bromberg.

(State or country) Germany.

PARENTS

10 NAME OF FATHER Louis Albert Grolock.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Amelia Grosse

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country) Germany

14 Informant Kezrah V. Grolock.

(Address) 3642 Malden ave.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-1929.

17

I HEREBY CERTIFY, That I attended deceased from Dec 26- 1929 to 12-30- 1929, that I last saw h.~~is~~ alive on 12-29- 1929, and that death occurred, on the date stated above, at 1:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY none

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) Chester Roland, M. D.

12-30, 1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arcadia Baltimore Co. Date of Burial Jan 1 1930

20 UNDERTAKER F Vernon Kochner ADDRESS 1532 Hollins st

C. R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

31

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52523

CERTIFICATE OF DEATH

166 E 52523

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Druid Hill Park St. 16-22 Ward)

2-FULL NAME Tilliah S. Coleman

(a) RESIDENCE NO. 1638 W. Lafayette Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26-1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Danville Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Nancy Womack

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Beverly Womack
(Address) 11 N. Mount St

15 Filed DEC 31 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poison Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Morrissey, M. D.

12/31 1929 (Address) 7623 Portland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Pikesville Md.	Dec 31 1929
20 UNDERTAKER	ADDRESS
Samuel Wemsley	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52524 ✓ 129 E 52524

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 628 N Carey ST. (16-23 WARD)

2—FULL NAME Lillian King Stewart

(a) RESIDENCE NO. 628 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

5a If married, widowed, or divorced (or) WIFE of Louis Stewart

6 DATE OF BIRTH (month, day, and year) Jan 17 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
25	24	11	14 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Wm King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Hathewright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary King (Mother)

(Address) 628 N Carey st

15 Filed DEC 3 1929, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Dec 29, 1929, that I last saw h.e alive on Dec 28, 1929 and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis & generalized Anasarca (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Yeatty, M. D.

Dec 30 1929 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 2 1930

20 UNDERTAKER Robert O Watkins ADDRESS 1515 Madison St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

USE

Cor.—10-10-29—A Co.—100 Bks.

(Tillie Smith)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52525

CERTIFICATE OF DEATH

E 52525

1-PLACE OF DEATH

City of Baltimore: (No. Alley Pratt Near Caroline St., 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tillie Smith

(a) RESIDENCE NO. Autumn 228 Bethel St.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Days Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unk

14 Informant Alice Freeman
(Address) 24 S Bethel St

15 Filed DEC 3 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ~~her~~ death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcohol

(duration) 1 yrs. mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) G. E. Stadel, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westview Cemetery	1/1/30
20 UNDERTAKER	ADDRESS
Robert Williams	1515 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48 E 52526

1—PLACE OF DEATH

REGISTERED NO. 1246

CITY OF BALTIMORE: (No. 100 W University Parkway ST., 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Payne Quesenberry.

(a) RESIDENCE NO. 100 W University Parkway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13-1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
90	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kingston Va

PARENTS

10 NAME OF FATHER James L. Quesenberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs H. C. Bowman

(Address) 100 W University Pkwy

15 Filed DEC 31 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31-1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Dec 31, 1929.

that I last saw h alive on Dec 30 1929

and that death occurred, on the date stated above, at 8 20 a. m.

The CAUSE OF DEATH* was as follows:

Coma of Days

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Lemmon, M. D.

Dec 31, 1929 (Address) 4509 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Jan 2nd 1930

20 UNDERTAKER Kertzman & Poe 1923 W Lafayette Ave ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-0E 52527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 7-4 Ward)

2-FULL NAME Geo. 6 Colleen

(a) RESIDENCE NO. Franklin Pone, Chambersburg, Pa. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 1869

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 60	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown 087
(b) General nature of industry, business, or establishment in which employed (or employer) Probably none.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Hopkins Hospital
(Address)

15 Filed ..., 19... C. Hampson June 2, 1930 Registrar

JAN 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage- Gastric Ulcer
Thrombus of Aorta

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins Hospital

What test confirmed diagnosis?

(Signed) Jos. H. Pace, M. D.

12/31 1929 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chambersburg Pa.	Jan 1930
20 UNDERTAKER J. M. Routzon	ADDRESS 2238 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52529

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-68 (WARD)

2-FULL NAME Mrs. Esther Fine

(a) RESIDENCE NO. 1647 Ruxton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj Fine

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE: Years 40 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Isaac Dressner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Emma Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Benj Fine

(Address) 1647 Ruxton Ave

15

N 1 - 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/31 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1924, to Dec. 31, 1924, that I last saw her alive on Dec. 31, 1924, and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast.

Metastasis to Pleura & Lungs

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray.

(Signed) S. J. Cohen, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: Jan 1st 1925

20 UNDERTAKER: Joseph Levin ADDRESS: 1439 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52529 E 52529

CERTIFICATE OF DEATH

51

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 828 Brooks Lane St. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Levinsohn

(a) RESIDENCE NO. 828 Brooks Lane ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Levinsohn

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mayer Schoen

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose —

12 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1437 E. Balto St

15 Filed JAN 1 - 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/1930

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to Dec 31st, 1929, that I last saw her alive on Dec 31st, 1929, and that death occurred, on the date stated above, at 12 01 9m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis and diabetes

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B. Kaden, M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Jan 1 1930
UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CA... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is v... important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Dix

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52530

CERTIFICATE OF DEATH

100-901 E 52530

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 9-18 Ward)

2-FULL NAME George W. Dix

(a) RESIDENCE NO. 1920 Sherwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mirtle A. Dix

6 DATE OF BIRTH (month, day, and year) July 15/1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster-self
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. W. Dix

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Betty Kelly

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mirtle A. Dix
(Address) 1920 Sherwood Ave

15 Filed ... 19 ... St. Joseph Hospital, Inc.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia (Primary)

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J S Hiden M. D.

12/31/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cemetery Hampden

DATE OF BURIAL 1/2 1930

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 1 - 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52531

CERTIFICATE OF DEATH

35 E 52531

1—PLACE OF DEATH Baltimore City Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 14-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Curtis

(a) RESIDENCE NO. 1408 Rutter ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in ~~city or town where above address is situated~~ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of wife-Julia Curtis

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) Unknown
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Curtis.

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emma Miles

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Maryland

14 Informant Hosp. Records.
(Address) Balto. City Hosp.

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 12-5-, 1929, to 12-30, 1929, that I last saw him alive on 12-30, 1929, and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of prostate

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Fred M. Dunkwall, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 1 1930

20 UNDERTAKER Wm Ns S Smith — ADDRESS 2513 Hoffman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

JAN 1 - 1930

Cor.—10-10-29—A Co.—100 Bks.

E 52532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 188-01 ✓ E 52532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Md Gen'l Hosp. St. 11-24 Ward)

2-FULL NAME Mc Kinley Cutsail

(a) RESIDENCE NO. Sparrow Point Md St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: Colored
5 Single, Married, Widowed or Divorced, (write the word): Married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mulvey
6 DATE OF BIRTH (month, day, and year): 1899.
7 AGE: Years 30 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Sparrow Point
(c) Name of employer: L & Co
9 BIRTHPLACE (city or town)
(State or country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address): Sparrow Point Co Records

15 Filed 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows: Accident. R.R.
Fractured Pelvis.
(duration) hour. mos. ds.
CONTRIBUTORY (Secondary) Caught between freight Cars.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sparrow Point R R
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy
(Signed) H. Leslie Smith, M. D.
Coroner
(Address) Dec 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia S & C
DATE OF BURIAL: Jan 1 1930
ADDRESS: Baltimore Md

20 UNDERTAKER: J. L. Brown & Son
Pen. R R

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated CAREFULLY. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52533 ✓ E 52533

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 Cole st. S. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Velton

(a) RESIDENCE. No. 1638 Cole st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susianna Velton

6 DATE OF BIRTH (month, day, and year) ? 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Romia

PARENTS

10 NAME OF FATHER Geo Velton Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Romia

12 MAIDEN NAME OF MOTHER Mary Melia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Romia

14 Informant S. Velton

(Address) 1638 Cole st

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30/29. 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26/29, 19..., to Dec. 30/29., 19..., that I last saw h. alive on Dec. 30/29., 19..., and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible]

19 (Address) Dec. 31/29. 33 Hanover st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 1/2.

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins

JAN 1 - 1930

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52534

CERTIFICATE OF DEATH

131 E 52534

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Sinai Hosp St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Hall

(a) RESIDENCE NO. 1739 N Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Hall

6 DATE OF BIRTH (month, day, and year) Dec 6 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	73	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Amer Express Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER James Hall

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Randall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant

(Address) Hospitals

15 Filed JAN 1 1930 C. HAMPSON JONES, M. D. Registrar

By AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

12-31-29

17 I HEREBY CERTIFY, That I attended deceased from 12-28-29, to 12-31-29 19

that I last saw h in alive on 12-31-29, 19

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows

Hydro-pyelo-nephrosis L

Acute Hemorrhagic Diathesis ?

(duration) yrs. mos. ds.

CONTRIBUTORY Uremia

(Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical

What test confirmed diagnosis?

(Signed) Jno Symphins, M. D.

(Address) Mt Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Jan 2 1930

20 UNDERTAKER John Ulrich ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 52535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 52535

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 912 N. Mount St. 16-2W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Hawkins

(a) **RESIDENCE NO.** 912 N. Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19 27

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	2	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Bernard Hawkins

11 BIRTHPLACE OF FATHER (City or town)

(State or country) St Marys Co. Md

12 MAIDEN NAME OF MOTHER Bessie Simms

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Annapolis Md

14 Informant Father

(Address) 912 N Mount St

15 Filed ..., 19 ... Registrar

JAN 1 - 1930 For C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-1929

17 I HEREBY CERTIFY, That I attended deceased from 12-23-, 1929, to 12-30-, 1929, that I last saw h[illegible] alive on 12-29-, 1929, and that death occurred, on the date stated above, at 10:10 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Exposure

[illegible] (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank Saunders M. D.

12-30-1929 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Jan 1 1930 — Date of Burial

20 UNDERTAKER David Carroll Sons — ADDRESS 916

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52536

CERTIFICATE OF DEATH

31 E 52536

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N. Gilmore ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Purnell B. Boom

(a) RESIDENCE NO. 233 N. Gilmore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Boom

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Hugh Boom

11 BIRTHPLACE OF FATHER (city or town) [illegible] (State or country) Maryland

12 MAIDEN NAME OF MOTHER [illegible]
Bertie Collins

13 BIRTHPLACE OF MOTHER (city or town) Kingston (State or country) Jamaica, B.W.I.

14 Informant Robert Boom
(Address) 233 N. Gilmore

15 Filed JAN 1 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 10-27-29, 19 29, to 12-30-29, 19 29, that I last saw h[illegible] alive on 12-29-29, 19 29, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign & symptom

(Signed) John E. L. Campbell, M. D.

, 19 (Address) 724 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 1 1930
20 UNDERTAKER Daniel Forbes	ADDRESS 916 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

AN

Spec.—2-29-28—L. F. S.—500 Blks.

E 52537 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52537

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 231 W Chase ST. 11-24 WARD)

2—FULL NAME Maria Jones

(a) RESIDENCE NO. 231 W. Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jones

6 DATE OF BIRTH (month, day, and year) 9/9/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Own

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant: Rebecca Jones

(Address) 231 W Chase St

15 Filed JAN 1 1930, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1929, to Dec 30, 1929, that I last saw h[illegible] alive on Dec 29th, 1929 and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis
with Arterial Sclerosis
(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) 1 yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Gustav Lehmann, M. D.

, 19 (Address) 656 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Jan 1, 1930

20 UNDERTAKER: Dennis Easton Co — ADDRESS 916

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

(Aderson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52538

CERTIFICATE OF DEATH

101-001 E 52538

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Aderson

(a) RESIDENCE NO. 932 Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Boxl Aderson

(Address) 232 Madison ave

Filed JAN 1 1930 19 C. HAMPSON JONES (Registrar)

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 31st 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 22nd, 1929, to December 31st, 1929, that I last saw h[illegible] alive on December 31st, 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, right lower lobe

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Lewis P. Yeuley, M. D.

12-31-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sunset Co.	1-1-1930
20 UNDERTAKER David Corbin	ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Samuel D. Myers.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 52539

CERTIFICATE OF DEATH 1929

E 52539

1—PLACE OF DEATH

REGISTERED NO. 12-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 208 Northway ST., (or WARD)

2—FULL NAME Dr S N Myers

(a) RESIDENCE NO. 208 Northway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Brandt

6 DATE OF BIRTH (month, day and year) Aug 4 1846

7 AGE	83 Years	4 Months	27 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mechanicsburg, Pa.

PARENTS

10 NAME OF FATHER Saml N. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mechanicsburg Pa

12 MAIDEN NAME OF MOTHER Nancy Meily

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Amerille Pa

14 Informant Mrs R S Hunter

(Address) 208 Northway Baltimore

15 Filed, 19 1930 HAMPSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31/29

17

I HEREBY CERTIFY, That I attended deceased from 11/13, 1928, to 12/20, 1929

that I last saw h[illegible] alive on 12/20, 1929

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis
chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys signs

(Signed) C Hutton Brown M. D.

12/31, 1929 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsburg W. Va	Jan 3 1930

20 UNDERTAKER	ADDRESS
John B Spence	1325 N. Carlton St

NATION should be carefully supplied. Note should be made herein. If the information called for in any item is unknown or cannot be ascertained by the undertaker, it should be stated. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 52540 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52540

CERTIFICATE OF DEATH.

21-24 48

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 East St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARGARET E. ANACKER Marg. E. Anacker

(a) Residence No. 1502 East St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of John Anacker

6-DATE OF BIRTH (month, day and year) June 8 1864

7-AGE, 64 yrs. 11 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) John Lehman

(Address) 1502 East St

15-

Filed JAN 1 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 30, 1929

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 19 29, to Dec 30, 19 29, that I last saw h— alive on Dec 28, 19 29, and that death occurred, on the date stated above, at 3 45 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Influenza

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

12/31, 1929 (Address) 507 Lenox

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: Jan 2, 1930

20-UNDERTAKER: Mr & Mrs. John W. Teufelson — ADDRESS: 801 W. Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52541

CERTIFICATE OF DEATH

X 120-001 E 52541

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 249

CITY OF BALTIMORE: (No. 33rd & Calvert Sts - ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Neil A. Sinclair (Augusta)

(a) RESIDENCE NO. Fayetteville, North Carolina ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Niel A. Sinclair

6 DATE OF BIRTH (month, day, and year) May 31, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	66	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Joseph Wath

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Fatima Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mrs. Harrison (Daughter)
(Address) 3216 Guilford Ave. City

15 Filed JAN 2 - 1930 19 ... H. S. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1929, to Jan 1, 1930, that I last saw her alive on Jan 1, 1930 and that death occurred, on the date stated above, at 625 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic edema of brain
c Generalized Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia P.O.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec. 30, 1929

Was there an autopsy? No

What test confirmed diagnosis? Exploration at Operation

(Signed) Charles G. Cummings M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fayetteville N.C.	Jan 2 1930

20 UNDERTAKER Henry J. Bukema Sons ADDRESS 1111 Mulberry St

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52542

CERTIFICATE OF DEATH

100-901 E 52542

1—PLACE OF DEATH

REGISTERED NO. 27-56

CITY OF BALTIMORE: (No. 3804 Tear Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hilbred Geraldine Hodges

(a) RESIDENCE NO. 3804 Tear Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 DATE OF BIRTH (month, day, and year) Nov 8, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George F. Hodges.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary V. Todd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant Mrs. Hest Hodges

(Address) 3804 Tear Ave.

15 Filed JAN 2 1930 19... H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-26 1929 to 12-30 1929

that I last saw h[illegible] alive on 12-30 1929

and that death occurred, on the date stated above, at 10 7 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (bronchial)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home address

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Henry Tuttle M. D.

12-31 1929 (Address) 3902 Overlandale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan 2 1930

20 UNDERTAKER	ADDRESS
Wm. Tuckner Sons	North & Pa

IMPORTANT—Before signing, be certain that all items are answered. Any alteration or erasure renders certificate void. Statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52543

CERTIFICATE OF DEATH

90 ✓ E 52543

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Wallbrook Ave. WARD) 15-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel L. Baugert

(a) RESIDENCE NO. 3108 Wallbrook Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie D. Baugert

6 DATE OF BIRTH (month, day, and year) Mar. 4, 1857

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Purchasing Agt. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Oil Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Philip Baugert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Einsel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mollie B. Kurtz

(Address) Lancaster Pa

15 JAN 2 - 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Dec 31, 1929, that I last saw h[illegible] alive on Dec 31, 1929 and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis — (duration) (from history 2) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Supposed

(Signed) Walter Niblett, M. D.

Dec 31 1929 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Jan 2 1930

20 UNDERTAKER Thos. McKnew & Sons ADDRESS Morrell Pa

Spec.—8-16-29—L. F. S.—100 Bks.

E 52544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 52544

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 122 S. Ellwood Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George H. Eitel

(a) RESIDENCE NO. 122 S. Ellwood Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth S. Eitel

6 DATE OF BIRTH (month, day, and year) Nov. 6. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schlundebury, Kundle Co

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Eitel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Louisa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Elizabeth S. Eitel

(Address) 122 S. Ellwood Ave

15 Filed JAN 2 - 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31. 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1929, to Dec 31 1929, that I last saw h[illegible] alive on Dec 31 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Emmett F. Greene, M. D.

Jan 2, 1930 (Address) 1900 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 4 1930
20 UNDERTAKER	ADDRESS
George W. Zirkin	1737 E Eager St.

Before signing be carefully supplied. Note: Should be signed IMMEDIATELY. Particular attention should be given to the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52545

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52545

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 1001

CITY OF BALTIMORE: (No. 33rd St & Calvert ST. 17-H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs E. Raymond Turner

(a) RESIDENCE NO. 14 Bishops Rd ST., WARD Guilford, Baltimore.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs E. Raymond Turner

6 DATE OF BIRTH (month, day, and year) May 28, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland, (Baltimore)

PARENTS

10 NAME OF FATHER Mr Charles Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosalind Flynn

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Deceased E. Raymond Turner

(Address) 14 Bishops Road

15 Filed 1930 C. HUMPSON JONES, M. D. 19 Registrar

N 2 - 1930 Mf

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31/29

17 I HEREBY CERTIFY, That I attended deceased from 12/27, 19 29, to 12/31, 19 29, that I last saw him alive on 12/31/29, 19 and that death occurred, on the date stated above, at 3.28 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, right

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Course.

(Signed) Franco V. Ulrich M. D.

1/31/1930 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Jan 2nd 1930

20 UNDERTAKER Henry H. Jenkins & Sons Co.

ADDRESS Druid Hill Ave & Colvert St

mation should be carefully supplied. Abbreviations should not be used. Cause of death must be stated CLEARLY. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52546

CERTIFICATE OF DEATH

57 ✓ E 52546

1—PLACE OF DEATH Home for Incurables — REGISTERED NO.

CITY OF BALTIMORE: (No. 40th St. & Cedar Ave ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Smith

(a) RESIDENCE NO. Home for Incurables ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin A. Smith

6 DATE OF BIRTH (month, day, and year) May 22, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Alvin Phiny

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maine

12 MAIDEN NAME OF MOTHER Jane Willis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Home for Incurables
(Address) 40th & Cedar Avenue

15 Filed 1930 S. HARRISON JONES, M. D.
Registrar

JAN 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31" 29

17 I HEREBY CERTIFY, That I attended deceased from Dec 18" 1929 to Dec 30 1929

that I last saw her alive on Dec 30" 1929

and that death occurred, on the date stated above, at 12¼ a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gangrene (dry) of foot

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam —

(Signed) W W B Mayo M. D.

Dec 31 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery. DATE OF BURIAL 1/2 1930

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Avenue

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52547

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52547

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Hanley.

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mt Hope Records

(Address): Mt Hope Retreat.

15 Filed JAN 2 1930 16 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Dec. 31, 1929, that I last saw her alive on Dec. 31, 1929 and that death occurred, on the date stated above, at 1. Noon m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Gastro Enteritis)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Probably Unknown (duration) 36 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

. 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/3/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52548

CERTIFICATE OF DEATH

31 ✓

E 52548

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2709 W North Ave 15-68 Ward)

2-FULL NAME Viola M. Burnett

(a) RESIDENCE NO. 2709 W. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John

6 DATE OF BIRTH (month, day, and year): ~~Feb 12~~ 1906

7 AGE: Years 23 | Months 10 | Days 19 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Va
(State or country): "

PARENTS

10 NAME OF FATHER: Wallace Carlisle

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country): "

12 MAIDEN NAME OF MOTHER: Rosie Elwell

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country): "

14 Informant (Address): Wallace Carlisle 2709 W. North Ave

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Feinblatt, M. D.

Dec 31 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: 1/3 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 2 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 52549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52549

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 3-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Krummick

(a) RESIDENCE NO. 1628 Bank ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer) ? Of

(c) Name of employer ?

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Krummeck

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Talley

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Germany

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed DEC 1930, HARRY JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 11-26, 1929, to 12-30, 1929, that I last saw him alive on 12-30, 1929, and that death occurred, on the date stated above, at 7 40 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. over 35 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Post. P.C. Lab.

(Signed) Marvin H. McLean, M. D.

12-31, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 1/2/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 2 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 52550

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 52550

CERTIFICATE OF DEATH

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST. 47 ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Mc Knight

(a) RESIDENCE NO. 210 E. Lexington ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) D. C. N. Y.

PARENTS

10 NAME OF FATHER Peter Mc Knight ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Helen Mc Namee ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? N. Y.

14 Informant Husband
(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 12-26, 1929, to 12-30-, 1929, that I last saw him alive on 12-30, 1929 and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic; Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here + Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: P.C.

(Signed) Marvin W. Mc Lean, M. D.

12-31, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 2 1930
20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 2 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

52551 — E 52551

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3814 Dorchester Rd St.) (WARD) 45-63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Broger

(a) RESIDENCE NO. 3814 Dorchester Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE Sarita Broger

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Paul Broger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Perel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel F. Lerer

(Address) 3814 Dorchester Rd

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929 to Jan 1, 1930, that I last saw h— alive on Jan 30, 1930 and that death occurred, on the date stated above, at 845 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas F Bleke, M. D.

Jan 2 1930 (Address) 20 E Presto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Mausoleum

DATE OF BURIAL 1/2 1930

20 UNDERTAKER Jas Lewis

ADDRESS 1439 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52552

CERTIFICATE OF DEATH.

11-01 52552

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3-4 (WARD)

2-FULL NAME Allan Siff

(a) RESIDENCE NO. 233 S. Eden St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Siff

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Louis Siff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Esther Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Charles Siff

(Address): 233 S. Eden St

15 Filed JAN 2 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/31 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/15 , 1929 , to 12/31 , 1929.

that I last saw h~~e~~ alive on 12/31 , 1929 ,

and that death occurred, on the date stated above, at 7 55 m.

The CAUSE OF DEATH* was as follows:

Postmortem

Cardiac failure & pulmonary edema

Subacute nephritis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Perforated Peptic Ulceration (& peritonitis) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 12/15/29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Goodman M. D.

1/31, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herrn Rest

DATE OF BURIAL: 1/2 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eutaw St

N. B.—WRITE PLAINLY, with ordinary pen and ink. Every question on this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52553

CERTIFICATE OF DEATH

11-002

E 52553

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2209 Mondawmin ave ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barton P. Fleischman

(a) RESIDENCE NO. 2209 Mondawmin Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-20-1929

7 AGE	Years	Months	Days 11	If LESS than 1 day, ...hrs. or ....min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael S. Fleischman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newark N. J.

12 MAIDEN NAME OF MOTHER Lena M. Pollock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed JAN 2 - 1930 R.M.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/1/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929, to Jan. 1, 1930; that I last saw him alive on Jan. 1, 1930; and that death occurred, on the date stated above, at 9:50 a m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Peri-Cordi-tis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) Fred B. Smith M. D.

, 19 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 1/2 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52554

CERTIFICATE OF DEATH.

E 52554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew aged Home St. 27-54 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Diamond

(a) RESIDENCE No. Belvedere & Greenspring Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Shana Diamond

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years: abt 90. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439-E Balto St

15 Filed JAN 2 1930 19 H. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-5, 1929, to Jan-1-, 1930, that I last saw him alive on Jan-1-, 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myo-Cardial Insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Bendel M. D.

1/2, 1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mark Road

DATE OF BURIAL: 1/2 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001 E 52555

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 E. University Parkway ST.) 12-44 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clifford Hay Mansfield

(a) RESIDENCE NO. 305 E. University Parkway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rice

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER D. Clifford Mansfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Roxanna Hay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Elizabeth R. Mansfield

(Address) 305 E. University Pkwy.

15 Filed JAN 2 - 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Dec. 30, 1929, that I last saw him alive on Dec. 30, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis - Influenza.
not pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George M. Steele, M. D.

12/31 1929 (Address) 2035 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL Jan. 2, 1930

20 UNDERTAKER John O. Mitchell & Sons ADDRESS 1900 Eutaw Pl

Milton B. Mitchell

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

52556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 52556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 6 Liberty Heights Av. 15-58 WARD)

2—FULL NAME Cora Fannie Kraft

(a) RESIDENCE NO. 242 6 Liberty Heights Ave. ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maybury G. Kraft

6 DATE OF BIRTH (month, day, and year) Mch. 25.1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER ~~Michael Hooper~~

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Wm. Kraft

(Address) New York City

15 JAN 2 - 1930 Mrs. D. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31. 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Dec 31st, 1929, that I last saw her alive on Dec 31st, 1929 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(2nd attack)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis

(duration) 2 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard D. Mahon M. D.

. 19 (Address) 1211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Jany. 2, 1930

20 UNDERTAKER John O. Mitchell & Sons — ADDRESS 1900 Eutaw Place

John O. Mitchell & Sons

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52557

CERTIFICATE OF DEATH

129 ✓ E 52557

1—PLACE OF DEATH

REGISTERED NO. 30-21

CITY OF BALTIMORE: (No. Aged Womens Home ST. Fulton Ave & Franklin St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmira J.Smith

(a) RESIDENCE NO. Aged Womens M.E.Home ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 years mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Basil B.Smith

6 DATE OF BIRTH (month, day, and year) Nov.17.1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
81	✓	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) A.A.Co.Md. (State or country)

PARENTS

10 NAME OF FATHER Joseph Benson

11 BIRTHPLACE OF FATHER (city or town) A.A.Co.Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Mrs.Iola Stevens

(Address) Rochambeau Aparts.

15 Filed JAN 2 1930 SIMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 1. 30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929, to Jany 1, 1930, that I last saw h-er alive on Dec 30, 1929 and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) ✓ yrs. 3 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Geo L Shannon, M. D.

, 19 (Address) 700 N.Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Jany.3.1930 19

20 UNDERTAKER John C.Mitchell & Sons — ADDRESS 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52558

CERTIFICATE OF DEATH

101-001

E 52558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 420 W. Henrietta ST. 22-31 WARD)

2—FULL NAME John Beaty

(a) RESIDENCE NO. 420 W. Henrietta ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Beaty

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 35 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Beaty
(Address): 420 W. Henrietta St

15 Filed JAN 2 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/31/29

17

I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Dec 31, 1929.

I last saw him alive on Dec 30, 1929

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. N. Hatcher, M. D.

1/1, 1930 (Address) Drs Pa Hts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winston Salem N.C.

DATE OF BURIAL: Jan 2 1930

20 UNDERTAKER: S. L. Brown & Son

ADDRESS: 108 W. Monty

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52559

CERTIFICATE OF DEATH

162 E 52559

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 112 N. Port St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Carroll

(a) RESIDENCE NO. 112 N. Port St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): Dec. 28, 1829.

7 AGE: Years / Months / Days: 3. IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: William E. Carroll.

11 BIRTHPLACE OF FATHER (City or town): Warwick Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Henretta Ray.

13 BIRTHPLACE OF MOTHER (city or town): Fairview, Md.

(State or country)

14 Informant: William E. Carroll.

(Address) 112 N. Port St.

15 Filed JAN 2 - 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 Dec 31

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Dec 31, 1929, that I last saw h[illegible] alive on Dec 30, 1929, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ephemeritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

12/31, 1929 (Signed) H. E. Campbell M. D.

(Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial Jan 2, 1930

20 UNDERTAKER: C. Howard Evans ADDRESS 1[illegible] E. Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 52560

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3502 Buena Vista Ave.) (WARD 57)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriet Williams.

(a) RESIDENCE NO. 3502 Buena Vista Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham L. C. Williams

6 DATE OF BIRTH (month, day, and year) Feb 5, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Thomas White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm L. Williams

(Address) 3502 Buena Vista

15 Filed DEC 2 - 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Jan 1, 1930, that I last saw her alive on Dec 31, 1929 and that death occurred, on the date stated above, at 6 25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Asthma (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1/2, 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Jan 3 1930
20 UNDERTAKER Chronow Bros	ADDRESS 345 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 2 - 1930

Spec.—1-12-23—M&T—500 Bks.

E 52561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-901 E 52561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Booth ST.) 20-28 (WARD) 101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Eisenbaugh

(a) RESIDENCE NO. 2013 Booth ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Audrus Eisenbaugh

6 DATE OF BIRTH (month, day, and year) Nov 7-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	67	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Michael Toale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George L. Eisenbaugh

(Address) 2013 W. Fayette St

15 Filed JAN 2 1930 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2/30 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 30, 1929, that I last saw her alive on Dec 30, 1929, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) (duration) Chronic Nephritis yrs. 15 mos. ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E. Hellen Kenney M. D.

1/2, 1930 (Address) 2000 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Plain Cemetery DATE OF BURIAL Jan 4 1930

20 UNDERTAKER George L. Schwab ADDRESS 2101 Eutaw Ave.

Heading should be carefully supplied. Age should be stated EXACTLY. PHRASES showing the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

F8526/62

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 33 ✓ E 52562

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbert Allen

(a) RESIDENCE NO. Wise Ave. North Pt. Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/15/20

7 AGE: Years 9 | Months 6 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER Albert Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va —

12 MAIDEN NAME OF MOTHER Celia Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va —

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 2 1930 C. H. Heath Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31-29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Dec 31, 1929.

that I last saw h alive on Dec 31, 1929

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Gentonitis, tuberculosis

Enteritis, tuberculosis

Meningitis, tuberculosis.

(duration) yrs. 3 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Culture of peritoneal fluid

(Signed) C. G. Elmore, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Jan 2 1930

20 UNDERTAKER: Mrs. K. G. Elmore — ADDRESS 1225 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Date statement of occupation as req. important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 52563

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 518 S. Ann St. ST 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Apolonia Anna Kitowska

(a) RESIDENCE NO. 518 S. Ann St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Stephen Kitowski

6 DATE OF BIRTH (month, day, and year) Feb 1867 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62 ~~63~~		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER K. Golinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER T. Kafftaski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Z. Kitowski Son

(Address) 518 S. Ann St.

15 Filed APR 2 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to Dec. 31, 1929, that I last saw h.. alive on Dec. 31, 1929 and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John V. Szymbrzyn M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Jan. 4 1930

20 UNDERTAKER F. W. Ozazewski 1930

ADDRESS Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52564

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1505 Nelson Ct. ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaw Bylski

(a) RESIDENCE NO. 1505 Nelson Ct. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
12	13	6 7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Bylski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agatha Bajarek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant Frank Bylski

(Address) 1505 Nelson Ct.

15

Filed JAN 2 - 1930. 19 C. HILTON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 30

17

I HEREBY CERTIFY, That I attended deceased from Dec 10 19 29, to Jan 1 19 30

that I last saw h[illegible] alive on June 11 19 30

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rykard M. D.

Jan 2 19 30 (Address) 800 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Jan. 3 19 30

20 UNDERTAKER

ADDRESS

Continued

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32565

CERTIFICATE OF DEATH.

100-001

E 32565

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Cohen

(a) RESIDENCE NO. 3736 Reisterstown Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 27-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	10	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) pub

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Sam Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Lowchester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed JAN 2 - 1930 19 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 2, 1930,

that I last saw h[illegible] alive on Jan 2, 1930

and that death occurred, on the date stated above, at 215 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. DeAlesi, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 1/2 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52566

CERTIFICATE OF DEATH.

29 E 52566

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2519 Madison av ST. 13-59 WARD)

2-FULL NAME Cornelia Roberts

(a) RESIDENCE NO. 2519 Madison ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Roberts

6 DATE OF BIRTH (month, day, and year): July 3-1875

7 AGE: Years 54 Months 5 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co. Md.

PARENTS

10 NAME OF FATHER: Albert Forester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jane Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm Roberts (Address): 2519 Madison St.

15 Filed APR 2 - 1930, 19 H. Lester Jones, M. D. Registrar

Pur

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/30 1929

17

I HEREBY CERTIFY, That I attended deceased from 12/5, 1929, to 12/30, 1929, that I last saw h[illegible] alive on 12/20, 1929, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

about 3

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Pigott, M. D.

12/31, 1929 (Address) 1536 ave. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Jan 2 1930

20 UNDERTAKER: Samuel Hensley

ADDRESS: Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52567

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Pearl ST. 17-25 WARD)

2—FULL NAME David O. Mason

(a) RESIDENCE NO. 412 N. Pearl ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 686

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Mason (Address) 550 Druid Hill Ave.

15 Filed JUN 2 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Dec 31, 1929, that I last saw h[illegible] alive on Dec 30, 1929 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

I do not know

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Do not know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Assumed

(Signed) [illegible] M. D.

Jun 2, 1929 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grace Frederick	1/2 1930

20 UNDERTAKER: Samuel F. Hemsley ADDRESS 578 Pe

Spec.—2-29-28—L. F. S.—500 Bks.

E 52568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Harlem Av ST 16-27 WARD)

2—FULL NAME Mamie Boulden

(a) RESIDENCE NO. 1609 Harlem Av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Sept~~ 12-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	40	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Samuel Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bere Miranda

(Address) 1609 Harlem Ave

15 Filed JAN 2 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/29/29

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Dec 29, 1929, that I last saw her alive on Dec 28, 1929 and that death occurred, on the date stated above, at 10:25 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. L. McLeod M. D.

12/30, 1929 (Address) 2005 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 2 1930
20 UNDERTAKER Samuel L Nemsley	ADDRESS 578 N Bdle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52569

CERTIFICATE OF DEATH

153

E 52569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. (or) Ward)

2-FULL NAME John Heinkel

(a) RESIDENCE NO. 526 Montello St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10/1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Heinkle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant
(Address) Jacob Heinkle Edmondson Ave P.O.

15 Filed 1929 C. HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

A Cellulitis
Infect of R Foot & Leg
(duration) 2 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diabetes
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What confirmed diagnosis?

Signed J. C. Bladel, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem.

DATE OF BURIAL Jan 3 1930

20 UNDERTAKER E. Miller & Son

ADDRESS 723 Hilton

IMPORTANT.—WRITE PLAINLY, WITH CARE AND PEN.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52570

CERTIFICATE OF DEATH

90 ✓

E 52570

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2127 No. Henry ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Nicholas

(a) RESIDENCE NO. 2127 No. Henry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 3 mos. 5 ds. How long in U. S., if foreign birth? —yrs. —mos. —ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 26th 1874

7 AGE: Years 55 | Months 3 | Days 5 | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturer of Chewing

(c) Name of employer: Company

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Herman Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Susanna Lechner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sanne Thompson (Address) 2127 No. Henry St.

15 Filed ... 19... HARRISON JONES, M. D. Registrar

AN 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/31/29

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1927, to 12/31, 1929, that I last saw h... alive on 12/31, 1929, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Examination & Clinical

(Signed) E. A. Erlon, M. D.

12/31, 1929 (Address) 2105 N. Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1/2/30
20 UNDERTAKER	ADDRESS
J. S. Shipley	1850 N. Bolton St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 52571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52571

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1029 Brantley St. Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Doering

(a) RESIDENCE NO. 1029 Brantley St. Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 26 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ George V. Doering

6 DATE OF BIRTH (month, day, and year) March — 5th 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	71	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Louis Binder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Schotte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant George V. Doering

(Address) 1029 Brantley Ave

15 Filed 1 1930 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1929 19

17 I HEREBY CERTIFY, That I attended deceased from July 15 19 29, to Dec 31 19 29, that I last saw h.. alive on Dec 31 19 29, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) — yrs. — mos. 7 da.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hellen F. Freeman M. D.

. 19 (Address) 6 East Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Dec 31 1930

20 UNDERTAKER Clarence Bernard ADDRESS 733 W Lafayette Ave

N 2 - 1930

WHITE LEAFLET, WITH UNFOLDING INS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

B 52572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 52572

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Lanvale & Calvert STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Winecke

(a) RESIDENCE NO. Preston West 2nd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelaide Winecke

6 DATE OF BIRTH (month, day, and year): Sept 18-1863

7 AGE: 66 Years, 7 Months, 14 Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George A Winecke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Maryan Pluenhett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Samuel Winecke Baltimore Md

15 Filed JAN 2 - 1930

16 H. [illegible] JONES, M. D.

Registrar

JAN 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/2 1930

17

I HEREBY CERTIFY, That I attended deceased from 12-8-29, 19 , to 1-2-30, 19 ,

that I last saw him alive on 1-2-30, 19 ,

and that death occurred, on the date stated above, at 10 4 m.

The CAUSE OF DEATH* was as follows:

Cancer Prostate

(duration) yrs mos ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-10-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M H Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Jan 4 1930

20 UNDERTAKER: J. H. Elmer Funeral Home — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52573

CERTIFICATE OF DEATH

101-001 E 52573

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1301 Eutaw ST. 16-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Mahoney.

(a) RESIDENCE NO. 1301 Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 5 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James E. Mahoney.

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Mary Russell

12 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Ca.

14 Informant Mr Joseph Mahoney
(Address) 1141 W Fayette St.

15 Filed JAN 2 - 1930 CHARLES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 1, 1930, that I last saw h~~e~~ alive on Dec 31, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Dorsey, M. D.

1/2, 1930 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 4th 1930

20 UNDERTAKER John F Cowan Inc. ADDRESS 901 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52574

CERTIFICATE OF DEATH

66 E 52574

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1 E Balto St., 3-5 Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. ' ' St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

Filed JAN 2 - 1930 C. HAMPSON JONES, M. D. Registrar

4214 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

What was there an autopsy? Yes

What test confirmed diagnosis? Histology

(Signed) C. E. Glade, M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER D. Commissioner Health

ADDRESS JAN 2 - 1930

N. B.—WRITE PLAINLY, WITH CREATING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-25-AOC-[illegible]Bks.

E 52575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 ✓ E 52575

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 708 Bray St. 2-4 Ward)

2-FULL NAME Ignatz Litinski

(a) RESIDENCE NO. 708 Bray St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General naturo of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed JAN 2 - 1930 [illegible] Registrar

421 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pect

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) C & Lausson

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Hist Exam

What test confirmed diagnosis?

(Signed) C & Clarke M. D.

19 (Address) 1430 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 2 - 1930

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. Every question should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52576

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 25-77 Ward)

2-FULL NAME Ida A. Shipka

(a) RESIDENCE NO. 5700 Pennsylvania St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry find that said deceased came to Her Death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cor Hypocarates

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Autopsy M. D.

, 19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER
Commissioner Health.

ADDRESS JAN 2 - 1930

JAN 2 1930 HAMPSON JONES M

1216 THE MORGUE.

445

Information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

52577.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52577

CERTIFICATE OF DEATH.

161-001

21-28

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 Ward St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby (Boy) Beasley

(a) Residence No. St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 28-1929

7-AGE, / yrs. mos. ds.

If LESS than 1 day, 2 hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... Ward

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frederick Houston

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Era Beasley

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

11- (Informant) Era Beasley

(Address) 1421 Mad St. Balto. Md

13- Filed ..... 192.. Registrar.

4217

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 28, 1929

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929. 19.. to Dec. 28 19.29

that I last saw h. alive on Dec. 28 19.29

and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery (26 weeks).

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/30/29 (Address) Mgr. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. S HOPKINS HOSPITAL

DATE OF BURIAL. ..... 19....

20-UNDERTAKER. (Commissioner Health.

ADDRESS

JAN 2 1930

HAMPSON JONES, M. D.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Young ✓

E 52578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 E 52578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1619 Division St. 14-20 (WARD)

2-FULL NAME Irene Henson Young

(a) RESIDENCE NO. 1619 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerome Young

6 DATE OF BIRTH (month, day, and year) Jan 1, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	36	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry Henson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Susie Henson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant George R Henson

(Address) 1619 Division St

15 Filed ..... 19 .....

Registrar

AUG 2 - 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1927, to Dec 31, 1927, that I last saw her alive on Dec 29, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Treated By Dr Peden

(Signed) E W Henson Hrs, M. D.

1/1, 1930 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL 1/3/1928

20 UNDERTAKER Mrs. Leo. H. Holland

ADDRESS 1603 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52579

CERTIFICATE OF DEATH

100-001

E 52579

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 14-20 S... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Turner

(a) RESIDENCE NO. 1405 Myrtle Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	24 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Odd jobs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas H. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Garnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals.

15 Filed ... Registrar

JAN 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29-29

17 I HEREBY CERTIFY, That I attended deceased from 12-27-29, 19..., to 12-29-29, 19...,

that I last saw him alive on 12-29-29, 19...

and that death occurred, on the date stated above, at 5:50 A.m.

The CAUSE OF DEATH* was as follows:

Infarct of brain.

(duration) more than yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Marvin M. McLean, M. D.

Dec 30 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Auburn

DATE OF BURIAL 1/2/1930

20 UNDERTAKER Mrs. Geo. H. Kollas

ADDRESS 1631 Druid Hill Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52580

100-001

CERTIFICATE OF DEATH

E 52580

1—PLACE OF DEATH Baltimore City Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto Md 16-23 ST. WARD)

2—FULL NAME Alexander Heyward

(a) RESIDENCE NO. 102 Block Woodyard ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 045

(b) General nature of industry, business, or establishment in which employed (or employer) Junk man

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records City Hospitals

(Address) Balto City Hospitals

15 Filed 7 JAN 30 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29-29

17 I HEREBY CERTIFY, That I attended deceased from 8-20-, 1929, to 12-29, 1929

that I last saw him alive on 12-29, 1929

and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis Confusion & Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Henry F. Adams M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JAN 2 - 1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52581

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 52581

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 43-59

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Becker

(a) RESIDENCE NO. 2535 Salem ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Swingle

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..... 19 ..... Registrar

4220

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 12-17-29, 19..., to 12-30-29, 19..., that I last saw h.. alive on 12-30-29, 19... and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia ?

(duration) ... yrs. ... mos. 42 ds. ?

CONTRIBUTORY (Secondary) Myocarditis chronic ? Anemia.

Secondary (duration) ... yrs. ? mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C. Lab.

(Signed) Marion W. McLean, M. D.

12-31, 19 29 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 19

20 UNDERTAKER ....

ADDRESS ....

JAN 2 1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52582 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO. E 52582

CITY OF BALTIMORE: (No. Eastern Ave. ST., (or) WARD 12424)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Bell

(a) RESIDENCE NO. 546 Preston ST., E. B. M. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) no data

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cooke

(c) Name of employer no data

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Joe Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Bettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Baltimore City Hosp.
(Address) Eastern Ave

15 Filed 4222 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1929, to Dec. 29, 1929, that I last saw him alive on Dec 28, 1929 and that death occurred, on the date stated above, at 12 30 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmn Tuberculosis

(duration) unknown

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) unknown

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis Physical Exam

(Signed) [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

important. See instructions on back of certificates.

[illegible] Health.

Spec.—I-10-21—M&T—1500 Bks.

Lejsiak

52583

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52583

CERTIFICATE OF DEATH.

116-002

1-PLACE OF DEATH St Joseph Hosp.

CITY OF BALTIMORE: (No. ..... ST. 1-3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lejsiak

(a) RESIDENCE NO. 2717 Hudson St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5th yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) October 28-1910

7 AGE: Years 19 | Months 2 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Lejsiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Susanna Rozanska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Susanna Lejsiak

(Address) 2717 Hudson Street

Filed JAN 2 1930 19 H. LEE JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 19 29

17

I HEREBY CERTIFY, That I attended deceased from Dec 29, 19 29 to Dec 31, 19 29,

that I last saw him alive on Dec 31, 19 29,

and that death occurred, on the date stated above, at 8-05 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Acute Uremia Suppression

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 30/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) S H Barnico M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cemetery — DATE OF BURIAL: Jan 4 1930

20 UNDERTAKER: George A Weber — ADDRESS: 700 S Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

George Cunneen.

E 52584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (No. Broadway + Fairmount Ave 6-9 WARD)

REGISTERED NO. 172

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Baby Boy Cunneen

(a) RESIDENCE NO. Church Home + Infirmary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred • yrs. • mos. • ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 3 min.
✓	—	—	—	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Vincent Cunneen

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Gertrude Anna Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Father - (Address) Broadway + Fairmount Ave

15 Filed JAN 2 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw him alive on Jan 2 , 1929, and that death occurred, on the date stated above, at 7.22 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Biliary Cirrhosis?

a

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) ? - none

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy?

(Signed) James E Davis, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catonsville Cemetery

DATE OF BURIAL Jan 2 1930

20 UNDERTAKER Hugh Johnson Sons

ADDRESS Lexington + Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52585

CERTIFICATE OF DEATH

90 E 52585

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 N. Charles ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Thomas Clarke

(a) RESIDENCE NO. 929 N Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White American	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853 - Oct. 11.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Seventy six	Four	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Clarksville, (State or country) Howard County, Md.

PARENTS

10 NAME OF FATHER William Clarke

11 BIRTHPLACE OF FATHER (city or town) Clarksville, (State or country) Howard County.

12 MAIDEN NAME OF MOTHER Alvina Charlotte Watkins

13 BIRTHPLACE OF MOTHER (city or town) Walnut Grove, (State or country) Md

14 Informant His sister

(Address) 202 S. Chase Street.

15 Filed JAN 2 1930, 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1. 1930

17 I HEREBY CERTIFY That I attended deceased from Dec. 1 19 29 to Jan 1 19 30, that I last saw h alive on Dec. 31, 19 29 and that death occurred, on the date stated above, at 7. A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clarke, M. D.

Jan 2 1930 (Address) La Mota Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 1-3 1930

20 UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS Orchard & McCulloh Sts

Please print legibly, as this is only the property certificate. Full statements of occupation are very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-092 E 52586

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 St Paul ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret L. Gambrill

(a) RESIDENCE NO. 715 St Paul St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: George F. Gambrill

6 DATE OF BIRTH (month, day, and year): May 4 1851

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown, Md

PARENTS

10 NAME OF FATHER: Wm. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliz. Ea

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Florence M. Gambrill

(Address): 715 St Paul St

15 Filed Jan 2 19 30 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 28 19 29 to Jan 1, 19 30, that I last saw h alive on Jan 1 19 30 and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis.

(duration) 8 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis C. Clagett, M. D.

Jan 2 19 30 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemy.

DATE OF BURIAL: Jan 5, 1930

UNDERTAKER

ADDRESS: Chas O. Mitchell Inc 1200 Eutaw St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52587

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52587

CERTIFICATE OF DEATH

75-002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 St Paul ST. 1115 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME India J. Cassady.

(a) RESIDENCE NO. 711 St Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of John L. Cassady

6 DATE OF BIRTH (month, day, and year) January 18 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER W. S. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Russell A. Jones

(Address) 711 St Paul St

15 Filed JAN 2 1930 C. HUNTON JONES, M. D. Registrar

By Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22 1929, to Dec. 31 1929, that I last saw her alive on Dec. 31 1929, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 16 da.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Frantis S, M. D.

1930 (Address) 7 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jany 3 1930

20 UNDERTAKER John O'Mulloy & Son ADDRESS 1701 Eastern Ave

IMPORTANT—Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52588

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 363 Ellamount Ave. ST., 20-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma E. Wilson

(a) RESIDENCE NO. 363 Ellamount Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Wilson

6 DATE OF BIRTH (month, day, and year): 11-25-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	66	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co., Md.

PARENTS

10 NAME OF FATHER: Frank Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co., Md.

12 MAIDEN NAME OF MOTHER: Betsy Philips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co., Md

14 Informant: Thos. Wilson

(Address): 363 Ellamount Ave.

15 Filed: DEC 2 - 1930, 19.. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 1st. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1929. to Jan. 1st. 19 30.

that I last saw h.. alive on Jan. 1st. 1930. 19

and that death occurred, on the date stated above, at 1.15 p. m

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary): Mitral Ins.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

. 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem	Jan 5th 1930
20 UNDERTAKER: Chas. W. Dill	ADDRESS 3109 Frederick Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52589

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 52589

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore Gen Hosp (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Russell Boswell

(a) RESIDENCE NO. 1511 Poplar ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6th 1918

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry W. Boswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ida A. Whitman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Leroy Boswell Brother
(Address) 1511 Poplar St

15 Filed 1930, C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1-30

17 I HEREBY CERTIFY, That I attended deceased from 12-27, 1929, to 1-1, 1930;
that I last saw h[illegible] alive on 1-1, 1930
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Laudenitis, M. D.
19 (Address) South Baltimore Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	June 4 1929
20 UNDERTAKER	ADDRESS
F. A. Wannemann	702 Hanover

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52590

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 52590

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 48-W (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse Ricketts

(a) RESIDENCE NO. 1139 W. Franklin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 209

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Adam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Hupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 1 C. HAMPSON JONES, M. D. Registrar

N 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN-1-1930

17

I HEREBY CERTIFY, That I attended deceased from Dec-18, 1929, to 1-1, 1930, that I last saw h alive on January 1, 1930 and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Circulatory failure,
arteriosclerotic heart disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of prostate & of stomach (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm. W. Hose, M. D.

1/2, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery Woodlawn	Jan 3 1930
20 UNDERTAKER	ADDRESS
Powell & Albaugh	Woodlawn Md

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52591 90 E 52591

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 16-67

CITY OF BALTIMORE: (No. 3019 Grayson ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth K Stangl

(a) RESIDENCE NO. 3019 Grayson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if foreign birth? 81 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
(or) WIFE of William Stangl

6 DATE OF BIRTH (month, day, and year) April 26 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	95	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Krebs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary M Stangl

(Address) 3019 Grayson St

15 Filed JAN 2 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 1, 1930

that I last saw her alive on Jan 1, 1930

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Rahn, M. D.

1/1, 1930 (Address) 3002 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	Jan 4th 1930
20 UNDERTAKER	ADDRESS
George Schilling & Sons	112 E Monument

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52592

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 324-E-20- ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Resident

2—FULL NAME Katherine Evans Price

(a) RESIDENCE NO. 324-E-20- ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 18 ds. How long in U. S., if foreign birth? 52 yrs. 7 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph T. Price

6 DATE OF BIRTH (month, day, and year): May 14 1877

7 AGE — Years: 52 | Months: 7 | Days: 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John B. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Shrewsbury England

12 MAIDEN NAME OF MOTHER: Margaret O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant: Mrs Margaret E. Simpson (sis)

(Address) 324-E-20. St.

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-1-1930

17 I HEREBY CERTIFY, That I attended deceased from SEPT. 28, 1929, to JANUARY 1, 1930, that I last saw her alive on DECEMBER 31, 1929 and that death occurred, on the date stated above, at 1. A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of heart.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. H. Jones, M. D.

, 19 (Address) 8 East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan 4 1930.

20 UNDERTAKER: Stewart & Monn Co — ADDRESS: Balto.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52593

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 E 52593

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 18-N ST. (If outside City, write name of County) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Waters

(a) RESIDENCE NO. 243 N. Poppleton st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0-40

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed JAN 2 - 1930 223 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1929, to Jan. 1, 1930, that I last saw him alive on Jan. 1, 1930 and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

1-2, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 2 - 1930

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 52594

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 18-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Johnson

(a) RESIDENCE NO. Mount St. Near Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Richard Brasley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Records of

(Address) Balto. City Hospitals

15 Filed DEC 2 1930 224

JOHNS HOPKINS HOSPITAL

O. RAMSDELL JONES, M.D.

Commissioner of Health

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-30-29

17 I HEREBY CERTIFY, That I attended deceased from 12-6-29, 19..., to 12-30-29, 19..., that I last saw him alive on 12-30-29, 19..., and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Warren W. Sisson, M. D.

Jan 2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR REMOVAL: Cremation

UNDERTAKER: Thos. Eden

Commissioner Health

DATE OF BURIAL: Jan 10 1930

ADDRESS: 325 Cathedral

DEC 2 - 1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52595

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52595

CERTIFICATE OF DEATH

101

1—PLACE OF DEATH 3600 Hineline Rd.

CITY OF BALTIMORE: (No. ..... ST. 25-12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Price

(a) RESIDENCE NO. 3600 Hineline Rd. ST. ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie L. Price

6 DATE OF BIRTH (month, day, and year): June 23 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer): 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phoenix Md.

PARENTS

10 NAME OF FATHER: Thomas Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan M. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Nellie G. Price

(Address) 3600 Hineline Rd.

15 Filed ..... 19 ..... WILLIAM JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec-30, 1927, to Jun-2, 1930, that I last saw him alive on Jun-2, 1930, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) ..... yrs. ..... mos. 5-6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) L. Lloyd Johnson, M. D.

. 19 (Address) 4206 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side fer additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmiston Sta.	June 4 1930
20 UNDERTAKER	ADDRESS
Walter Davis	3307 Pine st.

OF DEATH in plain terms, so that it may be properly classified. Later statement of occupation is important. See instructions on back of certificates.

N 2 - 1930

Cor.—10-10-29—A Co.—100 Bks.

E 52596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-8 01 ✓ 52596

1-PLACE OF DEATH 339

City of Baltimore: (No. 529 S. Dallas St., 3-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Pinkney

(a) RESIDENCE NO. 239 S Dallas St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	✓	4	8 9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kingville
(State or country) Md

PARENTS

10 NAME OF FATHER James Pinkney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Herline

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant James Pinkney
(Address) 529 S Dallas St

15 Filed C. H. THOMPSON JONES, M. D. Registrar

N 2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) D 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Bronchites

6 d (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) of Laryngitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

Were findings confirmed at inquest?

(Signed) M. D.

, 19 (Address) 1436 Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 4/2. 1930.

20 UNDERTAKER Geo J Ruth

ADDRESS 1735 Hartford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52597

CERTIFICATE OF DEATH

179 E 52597

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 7-13 Ward)

2-FULL NAME Barbara M. Scholl

(a) RESIDENCE NO. 1063 E. Eager St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Adam Scholl

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Vincent L. Roth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Herbert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Geo. J. Roth (Bro.)
(Address) 1013 E. Eager St

15 Filed ..... 19.. C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h.r death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia- Accidental burns over buttocks & thighs.
Clothing caught from gas stove on Nov 30/29 at her home.
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Restricted at Hopkins

What test confirmed diagnosis?

(Signed) J. S. Cullen, M. D.

12/30 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer, County

DATE OF BURIAL Jan. 4 19 30

20 UNDERTAKER Henry Stoeckel Son, Inc.

ADDRESS 1301 E Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 2 - 1930

Spec.—1-10-21—M&T—1500 Bks.

E 52598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 10-14 (Ward) 101-801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M Ryan

(a) RESIDENCE No. 1053 Aisquith st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~(or WIFE)~~ Frances E. Ryan

6 DATE OF BIRTH (month, day, and year) May 5 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	37	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Robert Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rose White.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Frances E. Ryan (Address) 1053 Aisquith St

15 FILED JAN 2 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1929, to Jan 1- 1930, that I last saw h alive on Jan. 1, 1930, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Right Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) M M Lundrine M. D.

1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Jan. 4 1930

20 UNDERTAKER Henry Aberle Sons Inc. ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52599

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 420 E. 21st St. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Strahler

(a) RESIDENCE NO. 420 E. 21st. St. ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Strahler

6 DATE OF BIRTH (month, day, and year) Feb. 22 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) United Railway

(c) Name of employer and Elec. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John William Strahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Catherine Strahler

(Address) 420 E. 21st. St.

15 Filed 1-2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1929, to Dec 31, 1929, that I last saw h[illegible] alive on Dec 31, 1929 and that death occurred, on the date stated above, at 7.35 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Myocarditis, Interstitial

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Mackey, M. D.

, 19 (Address) 532 E. 22nd. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 3, 1930
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Eutaw St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 52600

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 S. Gilmor St. 14-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George R. Brennan, Sr.

(a) RESIDENCE NO. 121 S. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Brennan

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	60	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Ofc

(c) Name of employer National Casket Co.

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Edward Brennan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Catherine Toomey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Mrs. Mary A. Brennan

(Address) 121 S. Gilmor Street

15 Filed JAN 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929; to Dec 30, 1929; that I last saw him alive on Dec., 1929 and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Chas. Horton, Jr. M. D.

1/1, 1930 (Address) 888 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mar Cathedral Cem

DATE OF BURIAL Jan. 3" 1930

20 UNDERTAKER Joseph H. Cook

ADDRESS 1003 W. Baltimore St.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52601 HEALTH DEPARTMENT—CITY OF BALTIMORE 1002 52601

CERTIFICATE OF DEATH.

REGISTERED NO. 109

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. Washington St. 7-4 WARD)

2-FULL NAME Evelin Komsek

(a) RESIDENCE NO. 232 S. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 16 1924

7 AGE: Years 5 Months 9 Days 14 (15) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael Komsek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Pauline Kiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Michael Komsek

(Address) 232 S. Washington St.

15 Filed 2-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 19 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Jan 1, 1930, that I last saw her alive on Dec 31, 1929, and that death occurred, on the date stated above, at 1310 a.m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Septic throat

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? physical signs

(Signed) Leo Heller, M. D.

12-, 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem DATE OF BURIAL: Jan 4 1930

20 UNDERTAKER: John M Wilder & Son ADDRESS: Chester

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 52602 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 52602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4327 Wickford Road Roland Park) WARD 170 32

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Wells Pietsch

(Residence in Baltimore: No. 4327 Wickford Road Roland Park St.; 79 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 2nd, 1869
(Month) (Day) (Year)

7-AGE, 60 yrs. 3 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Architect
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Chicago Ill

PARENTS.

10-NAME OF FATHER, Charles F. Pietsch

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Florence Wells

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver C. Zell

(Address) Cambridge Apt

15- Filed ....., 191.... C. HAMPSON JONES, M. D.
Registrar.

2 - 1930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 1, 1930.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis
Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner.)
1/7, 1930 (Address) 3 E. 7 Rd Roland Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral

DATE OF BURIAL, Jan. 3rd, 1930

20-UNDERTAKER Henry J. Jenkins & Sons

ADDRESS Cathedral & The Catholic

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Name residence of OCCUPATION always important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52603

CERTIFICATE OF DEATH

90 ✓

E 52603

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3909 Keswick Road ST. 13-57 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Winston Livingston Edwards

(a) RESIDENCE NO. 3909 Keswick Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lavinia C. Edwards

6 DATE OF BIRTH (month, day, and year) May 29, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 266

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William M. Edwards

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Smith

13 BIRTHPLACE OF MOTHER (city or town) Harford County (State or country) Md.

14 Informant Wray A. Hoffman (Address) 3909 Keswick Road

15 Filed JAN 3 1930, 19..

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20. 1929. to Jan 1. 1930. that I last saw h alive on Dec 31. 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficency 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

19 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Jan 3 1930

20 UNDERTAKER Hugh Jackson & Sons ADDRESS N. Y. Pa

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52604

CERTIFICATE OF DEATH

90 ✓ E 52604

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2313 Ashland Ave ST., 7912 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Henry Buddenbohn

(a) RESIDENCE NO. 2313 Ashland Ave ST., 9. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The Late Catherine

6 DATE OF BIRTH (month, day, and year) Feb. 24 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Buddenbohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Buddenbohn

(Address) 2313 Ashland Ave

15 Filed JAN 3 1930 HAMILTON JONES, M. D. Registrar

Per Ralph

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to 12-31-29

that I last saw him alive on 12-31-29

and that death occurred, on the date stated above, at 1300 P.M.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.

1-3, 1930 (Address) 1001 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel

DATE OF BURIAL 1/3/1930

20 UNDERTAKER Louis J Heumann

ADDRESS 32 S. Broadway

Cor.—10-10-29—A Co.—100 Bks.

E 52605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 52605

1-PLACE OF DEATH

City of Baltimore: (No. 3119 Tate St. St. 25-16 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clementina Van Landingham.(C)

(a) RESIDENCE NO. 3119 Tate St. St., Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 22 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 11, 1929

7 AGE	Years	Months	Days 21	IF LESS than 1 day ..... hrs. or ..... min.
	0	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Clifton Van Landingham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Rachael Strawberry.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Rachael Van Landingham.(C)
(Address) 3119 Tate St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia.
unknown.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Theodore Steinhardt, M. D.
1/2, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem | DATE OF BURIAL 1/3/30

UNDERTAKER Ernest Williams | ADDRESS 1515 W. Lafayette Ave

JAN 3 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52606

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 52606

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST., 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Columbus Sharpes

(a) RESIDENCE NO. 1735 Ellsworth ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 11 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	17	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Godfrey Sharpes

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Odella Miller

12 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Md.

14 Informant Odella Miller

(Address) 1735 Ellsworth St.

15 Filed JAN 3 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/1/30

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 1, 1930, that I last saw h[illegible] alive on Jan 1, 1930 and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(duration) about 1 wk. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) B Harris, M. D.

1/4/30 19 31 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Jan 3, 1930
20 UNDERTAKER Mrs. K. A. Elbert	ADDRESS 1726 Ashland Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 52607 — 129 — B 52607

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2818 Simpson ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha E. Judson

(a) RESIDENCE NO. 2818 Simpson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Judson

6 DATE OF BIRTH (month, day, and year) Oct. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown. (State or country)

14 Informant John Judson (Address) 2818 Simpson st

15 Filed JAN 3 1930 19 H. W. Cook JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31st 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 29, to Dec 31 19 29, that I last saw h.er alive on Dec. 31 19 29 and that death occurred, on the date stated above, at 6 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Vascular Renal disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Hamilton, M. D.

1-2 19 30 (Address) 1202 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	Jan 3, 1930
UNDERTAKER	ADDRESS
Mrs. B. G. Elliott	1705 Eutaw

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52608

CERTIFICATE OF DEATH.

1172 52608

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 W. Biddle ST. 11-24 WARD)

2-FULL NAME Jerry Arthur Miller

(a) RESIDENCE No. 206 W Biddle ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of disease causing death, not mode of dying, such as heart failure, asthenia, etc.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 1927

7 AGE — Years: 2 — Months: 6 — Days: 4 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Jerry E. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Alma Inter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Junior S.C.

14 Informant: Jerry Miller Sr.
(Address) 206 W Biddle

15 Filed JAN 3 - 1930 E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 1, 1930, that I last saw h[illegible] alive on Jan 1, 1930 and that death occurred, on the date stated above, at 10.30A m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion following over eating and Constipation

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. McKee, M. D.

Jan 1, 1930 (Address) 1126 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Jan 3, 1930

UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1725 Division

Cor.—10-10-29—A Co.—100 Bks.

Thiebe

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52609

CERTIFICATE OF DEATH

E 52609

1-PLACE OF DEATH

City of Baltimore: (No. 517 N. Glover St., 7-10 Ward)

REGISTERED NO. 18-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oswald F. Thiebe

(a) RESIDENCE NO. 517 N. Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emilie P. Thiele

6 DATE OF BIRTH (month, day, and year) Dec 17/1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	0	15/14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Francis Thiele

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ermany

14 Informant Rose Franenberger
(Address) 3414 Harford Ave

15 Filed JAN 3 - 1930 W. H. Lee Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rt. Inguinal Hernia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Dalen, M. D.

1/2/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 4 1930

20 UNDERTAKER William J. Schaefer — ADDRESS 816 E. Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Mehl

E 52610 HEALTH DEPARTMENT—CITY OF BALTIMORE

45 ✓ E 52610

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2639 Hafer 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emilie Mehl

(a) RESIDENCE NO. 2639 Hafer St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 1 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of Fredrick Mehl

6 DATE OF BIRTH (month, day, and year) May 15, 1874

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	55	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ironwork

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Vincent Hammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Fredrick Mehl

(Address) 2639 Hafer St

15 Filed JAN 3 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929, to Jan 1 1930; that I last saw h[illegible] alive on Jan 1 1930 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Carcinomata of Rectum

Chr Intestinal Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hubert C. Stokes M.D.

1/2/30 (Address) 2157 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvert	Jan 4 30
20 UNDERTAKER Chas. L. Stevens	ADDRESS 1501 W Fayette St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52611

CERTIFICATE OF DEATH.

90 ✓

E 52611

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2900 E. Baltimore St., 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mayme C. Krafzer

(a) RESIDENCE NO. 2900 E. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. F. Krafzer

6 DATE OF BIRTH (month, day, and year): Nov 13 1886

7 AGE: Years 43 Months 0 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Louis Mauser

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna M. Schmidt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. Anna M. Mauser

(Address) 2900 E. Baltimore St

Filed JAN 3 - 1930

C. HUBERT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(History of Hypertension for some time)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. F. Cairns M. D.

(Coroner)

(Address) 12/30 19 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial Jan 4. 1930

20 UNDERTAKER: Elmer W. Conkey ADDRESS 924 E Eager St.

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52612

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

E 52612

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Hawkins

(a) RESIDENCE NO. 1533 Orleans ST., WARD
(Usual place of abode)

Length of residence ~~in city of death~~ ~~preceding death~~ occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jane B Hawkins

6 DATE OF BIRTH (month, day, and year) Unknown 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50 51	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Hawkins

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Arnold

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Maryland

14 Informant Hosp. Records.
(Address) Balto. City Hosp.

15 Filed ... 1930 HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Dec 31, 1929, that I last saw h[im] alive on Dec 31, 1929, and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Atrophic cirrhosis of liver

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Pulmonary embolism (duration) 1 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Fred M. Christopher M. D.

19 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 4 1930
20 UNDERTAKER John Resnick	ADDRESS 2008 Orleans

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1001

118 E 52613

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 134 N. Port St.) 6-10 Ward)

2-FULL NAME Christian Hartman

(a) RESIDENCE NO. 134 N. Port St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Hartman

6 DATE OF BIRTH (month, day, and year) Sept 30/1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carman Helper
(b) General nature of industry, business, or establishment in which employed (or employer) 618
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Hartman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Erbe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Kate Hartman (wife)
(Address) 134 N. Port St

15 Filed JAN 3 - 1930 H. M. Byron JOHNS M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiviency

Incarcerated Inguinal Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cairns, M. D.

1/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemy — DATE OF BURIAL Jan 4 1930

20 UNDERTAKER Jos Joerdens & Son — ADDRESS 2178 Pa

tion should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

E 52614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+185

E 52614

REGISTERED NO.

1-PLACE OF DEATH Md General Hosp.

City of BALTIMORE: (No. Howard + Madison St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Missmary W Cook

(a) RESIDENCE NO. Darlington, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: Years 72 Months Days

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen. duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cookesville (State or country) Md.

PARENTS

10 NAME OF FATHER Jord Cook

11 BIRTHPLACE OF FATHER (City or town) Cookesville (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Pearson

13 BIRTHPLACE OF MOTHER (city or town) Cookesville (State or country) Md

14 Informant Hospital Record (Address)

Filed JAN 3 - 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1930, to Jan 3, 1930, that I last saw h[illegible] alive on Jan 3, 1930, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Fracture left femur

Senile

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Cookesville, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Kerpelmeier M. D.

1/3 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Darlington Md — Date of Burial 1-6 1930

20 UNDERTAKER: Herbert S Bailey — ADDRESS: Darlington Md

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

5

E 52615

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST. 335-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. Tillett

(a) RESIDENCE NO. 335 Patapsco Ave ST. Brooklyn WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886, Aug 18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34 yrs. 43		4	14	

8 OCCUPATION OF DECEASED Asst Supt.

(a) Trade, profession or particular kind of work Employed by Standard Oil Co

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER James F Tillett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant South Balto Gen Hosp
(Address) Light st

15 Filed JAN 3 1930 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 2, 1930, that I last saw him alive on Jan 2, 1930 and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Perforated Appendicitis

Spreading peritonitis

Diabetes Mellitus

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Cardiac failure

Resp. failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Jan 1, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. A. Libaugh M. D.

1-2, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	1/4/ 1930
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

IMPORTANT. See instructions on back of certificates. DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52616

CERTIFICATE OF DEATH

46 ✓

E 52616

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillian Haines

(a) RESIDENCE NO. 511 N. Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Haines

6 DATE OF BIRTH (month, day, and year) June 15, 1892

7 AGE — Years: 37 Months: 6 Days: 16 IF LESS than 1 day ..... hrs. or ..... min.: 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Marshall

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Margert Lipkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Clinical Rec't (Address) Md. Gen. Hosp.

15 Filed JAN 3 - 1930 19 [illegible] Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1929, to Jan. 1, 1930, that I last saw her alive on Jan. 1, 1930, and that death occurred, on the date stated above, at 8:55 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with post peritonitis & intestinal

(duration) yrs. ? mes. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ? da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 12-24-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

1/1/30 (Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pauchman

Date of Burial: 1/4 1930

20 UNDERTAKER: Urmann Cook

ADDRESS: 1217 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52617

CERTIFICATE OF DEATH

129 E 52617

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital Ward 4b)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. B. Minnick

(a) RESIDENCE NO. 633 Walnut Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	64	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Patapsco Oil Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John M. E. Minnick

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ette Hardesty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JAN 3 - 1930 C. H. [illegible] Registrar

Reg'r

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-15, 1929, to 1-2, 1930, that I last saw him alive on Jan 2, 1930, and that death occurred, on the date stated above, at 12 25 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular-nephritis Uremia -

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical - Examination

(Signed) [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — Date of Burial 1/6 1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

No-E Preston 5-001 52618

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 1301 St. Charles St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Mitchell

(a) RESIDENCE NO. 1301 St. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Mitchell

6 DATE OF BIRTH (month, day, and year) July 10-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Alexander Mitchell

(Address) 1301 St Charles

15 Filed JAN 3 - 1930 JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 1929, to Jan 2, 1930, that I last saw h[illegible] alive on Jan 2, 1930 and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of V

Was there an autopsy? No

What test confirmed diagnosis? V

(Signed) Chas F Bloh, M. D.

Jn 3 1930 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 1/6 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

Fill in all items in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 52619

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital St., 77-30 Ward

2-FULL NAME Henry Wultze

(a) RESIDENCE NO. 1416 W. Camden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 27th 1865

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
64	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Fred Wultze

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Wultze

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Nolke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Samuel H Springer
(Address) 6903 Marlborough Rd

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Paley, M. D. Camden, M. D.

Jan 2/30 (Address) 4 Bosley Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 1/4 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Dr. France 2939 1903 Edgewood

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32620

REGISTERED NO. 90-69 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Union Mem Hospital St., Ward

2-FULL NAME Ella B Powell

(a) RESIDENCE NO. 2500 W. Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm M.

6 DATE OF BIRTH (month, day, and year) May 2. 1894

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
35	8	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Elkton Va

PARENTS

10 NAME OF FATHER Rufus Shiflett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Blanche

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Wm M. Powell
(Address) 2500 W Fayette St

15 Filed JUN 3 - 1930 [illegible] JONES M. Registrar

Ref 766

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Perforated Intestines due to an which she was riding collided with another

CONTRIBUTORY (Secondary) Fractured Femur - Fracture Shock (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fremont - 33rd

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical

(Signed) E. E. France M. D.

1/3. 1930 (Address) 2939 W. Edgewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 1/4 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52621

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 52621

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. Penn ST. 4th 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Scott

(a) RESIDENCE NO. 117 S. Penn ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 19 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Florence Scott

(Address) 117 S Penn St

15 Filed JAN 3 - 1930 H. JACKSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/1/30

17 I HEREBY CERTIFY, That I attended deceased from 12/28, 1929, to 1/1, 1930, that I last saw her alive on 1/1, 1930, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Recurrent Bron-chitis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Jackson Jones, M. D.

1/2, 1930 (Address) 908 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem. | DATE OF BURIAL 1/3 1930

20 UNDERTAKER Samuel F. Kemsley | ADDRESS Middle St

Spec.—1-10-21—M&T—1500 Bks.

E 52622 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 90 E 52622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (Ward) 11-15

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Walden

(a) RESIDENCE No. 600 E. Eager ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 1870

7 AGE — Years: 59 — Months: 4 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 087

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Richard Walden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dec.

12 MAIDEN NAME OF MOTHER: Mary M. Molloy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dec.

14 Informant: Catherine Neville
(Address): 600 E. Eager St.

15 Filed JAN 3 - 1930 19 ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929 to Jan. 2, 1930, that I last saw h[illegible] alive on Jan. 2, 1930, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with decompensation.

(duration) yrs. One mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters — DATE OF BURIAL: Jan 4 1929

20 UNDERTAKER: Pike Wakefield — ADDRESS: 914 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52623

CERTIFICATE OF DEATH.

10-001 E 52623

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. ..... ST. 12-50 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Mrs.~~ E. Peronne McCaffrey

(a) RESIDENCE NO. 406 E. 25th ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Warren McCaffrey

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Mullan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna E. Adam

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Pauline A. Mullan
(Address) 710 Springfield Ave., Govans

15 Filed JAN 3 - 1930 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec, 31, 1929 to Jan 2, 1929.

that I last saw h[illegible] alive on Jan 2, 1929

and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris 12th. Hypo.
Cardiac Insufficiency

(duration) 4-5 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio + lobar pneumonia

(duration) yrs. 1 mos. 19 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jos. [illegible] Mullan, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1/6 1930

20 UNDERTAKER Henry W. Myers & Son

ADDRESS 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

E 52629

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52624

CERTIFICATE OF DEATH

1-PLACE OF DEATH Providence Hosp. 178

City of Baltimore: (No. 1142 Shield St., 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gloria Jones

(a) RESIDENCE NO. 1142 Shield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Feb 27 - 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	4	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Jones

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Edward Jones
(Address) 1142 Shield

15 Filed ..... 19 ..... Registrar

JAN 3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident

2nd degree burns

(duration) ..... yrs. few hours mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Kehoe M. D.

(Address) Jan 3 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Jan 3, 1930

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 3224 Sherwood Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52625

CERTIFICATE OF DEATH

E 52625

REGISTERED NO. 17-24-178

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1142 Shield St. 17-24 Ward)

2-FULL NAME Dorothy Jones

(a) RESIDENCE NO. 1142 Shield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) April 21 - 1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) N. Ca.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Jones

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant Edward Jones
(Address) 1142 Shield

15 Filed JAN 3 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident
2nd Degree burn.
Home.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Defective wiring
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Fred Linke M. D.
(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 3, 1930
20 UNDERTAKER	ADDRESS 32 N. Schroeder St
Mrs. Katie R. Williams	

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 52626

1—PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. 17-50

CITY OF BALTIMORE: (No. Calvert & 33rd ST.) (WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Harry Harman

(a) RESIDENCE NO. 2719 Guilford Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 10 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Roddy Harman

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Balto. Equit.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Harman

11 BIRTHPLACE OF FATHER (city or town) Holland
(State or country)

12 MAIDEN NAME OF MOTHER Jeanette Hess

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Records
(Address)

15 Filed JAN 3 - 1930 19 [illegible] Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to Jan. 2, 1930, that I last saw h[illegible] alive on Jan. 2, 1930 and that death occurred, on the date stated above, at 5:32 P. m.

The CAUSE OF DEATH was as follows:

Diabetes Mellitus

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Malnutrition

Abscess (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Findings

(Signed) William R. Hargo, M. D.

Jan 2, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 1/6 1930

20 UNDERTAKER Chas. P. Ward & Son — ADDRESS 1118 W. North Ave.

Cor.—12-9-25—A Co.—200 Bks.

E 52627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 52627

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1835 N. Bond Street St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella J. Ellis

(a) RESIDENCE NO. 1835 N. Bond Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred about 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	About 60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Ellis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ann Keneally

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Henry Ellis

(Address) 1835 N. Bond Street

JAN 3 - 1930 BALTIMORE, MD.

Filed Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency
Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Cain (Coroner) M. D.

Jan/2/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial Jan 4 1930

20 UNDERTAKER Chas R Pruce & Son ADDRESS 1180 Mt Roy Ave

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 132838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 52628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 5-6 ..... WARD)

2—FULL NAME Lena Contee

(a) RESIDENCE NO. 1119 Mc Elderry ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Jan 24- 90

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	39	11	8 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Wm Fleurney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Ella Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant Records

(Address)

15 Filed JAN 3 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan - 1 - 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Jan 1, 1930, that I last saw her alive on Jan 1, 1930 and that death occurred, on the date stated above, at 845 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension - at least 5 yrs.

Hemiplegia - 3 days

Circulatory failure - 3 days

Nephritis ..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Balt.

Did an operation precede death? No Date of

Was there an autopsy? Yes at J.H.H.

What test confirmed diagnosis? Autopsy

(Signed) J. F. Snyder, M. D.

Jan. 2, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cem	1-4 1930
UNDERTAKER	ADDRESS
Byron & Knight	1218 Mc Elderry St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

ES 2629 ✓ ES 2629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 52629

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 137 N. Wolfe ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benj. Plotnick

(a) RESIDENCE NO. 137 N. Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta Plotnick

6 DATE OF BIRTH (month, day, and year) Dec

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Kosher Trader

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Plotnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant F. Rewes

(Address) 1429 E Baltimore

15 Filed JAN 3 - 1930 C. HAMPSON JONES, M. D. Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1929, to Jan 2, 1930, that I last saw h[illegible] alive on Jan 2, 1930 and that death occurred, on the date stated above, at 1 40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. Kadner, M. D.

, 19 (Address) 2306 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL 1-3 1930

20 UNDERTAKER Jack Rewes

ADDRESS 1429 E Balto. St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52630

CERTIFICATE OF DEATH

REGISTERED NO. [illegible]30

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 St Johns Rd St. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G Gorman

(a) RESIDENCE NO. 614 St Johns Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie E Gorman

6 DATE OF BIRTH (month, day, and year): Sept 15 45

7 AGE: Years 84 Months 3 Days 16

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Mer

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Thomas E Gorman

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Whittemore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Irvin Gorman

(Address): 614 St Johns Rd.

15 Filed JAN 3 - 1930 O. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929

Dec 31

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Dec 31, 1929,

that I last saw him alive on Dec 31, 1929,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Impacted fracture of femur

(duration) yrs. 3 mos. 13 ds.

CONTRIBUTORY (Secondary): Hypostatic pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at his place of business

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Ralph L Stoyt, M. D.

, 19 (Address) 262 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

Date of Burial: Jan 3, 1929

20 UNDERTAKER: W M Preston

ADDRESS: 2238 N [illegible] with

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

E 52631

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 1125 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Joseph B. De Shazo~~ Joseph B. DeShazo

(a) RESIDENCE NO. 123 N Greene ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	59	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore Md

14 Informant Mrs H. F. Lee Attorney
(Address) 2620 Pleasant Valley Rd

15 Filed JAN 3 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Jan 2, 1930, that I last saw him alive on Jan 2, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) ..... yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 12-11-29

Was there an autopsy? no

What test confirmed diagnosis? Frozen Section Tumor

(Signed) Emmett Spencer jr. M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shrewsbury Pa

DATE OF BURIAL Jan 4 1930

20 UNDERTAKER George L. Smith

ADDRESS 453 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52632

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5704 Ethelbert Ave. ST. 27-55 WARD)

2—FULL NAME Isabel Orem

(a) **RESIDENCE NO.** 5704 Ethelbert Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 0 mos. 25 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles A. Orem

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER David Henley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Isabel Krause

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Harry A. Forman
(Address) 5704 Ethelbert Avenue

15 Filed [illegible] Registrar

3-1930

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 '30

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 19 30, to Jan 1 19 30, that I last saw h[illegible] alive on Dec 30, 19 29 and that death occurred, on the date stated above, at 2.P m.

The CAUSE OF DEATH* was as follows: Myocardial Degeneration

Contributed but Secondary, for ... Years

CONTRIBUTORY (Secondary) Cancer Congestion of Kidneys (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) Henry Cassedy, M. D.

1/3, 19 30 (Address) Upland 5 6

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 1/4 19 30

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 805 W. Calvert

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52633

CERTIFICATE OF DEATH

74-001 ✓ E 52633

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 W. Fayette ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. Ahern

(a) RESIDENCE NO. 1826 W. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ahern

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	72	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John Ahern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna Prendeville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Alfred J. Ahern

(Address) 1826 W. Fayette St.

15 Filed 1-3-1930 C. HAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1929, to Jan 2, 1930, that I last saw him alive on Jan 1st, 1930 and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 week yrs. mos. ds.

CONTRIBUTORY (Secondary) paralysis 1 week

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical symptoms

(Signed) S. S. Landis, M. D.

1/3, 1930 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem	Jan 4, 1930
20 UNDERTAKER Ralph S. Cook	ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52634

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Loudon Park Cemetery Ga ST., [illegible] WARD)

REGISTERED NO. [illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew J. Haight

(a) RESIDENCE NO. Loudon Park Cemetery Gat ST., House

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel A. Haight

6 DATE OF BIRTH (month, day, and year) June 9, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	78	6	22 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas W. Haight

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York

12 MAIDEN NAME OF MOTHER Elizabeth Skidmore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Miss Kate V. Haight

(Address) Loudon Park Cemetery Gate House

15 Filed JAN 3 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929 to Jan 1 1930; that I last saw him alive on Jan 1 1930 and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hemoplegia

Complications - Senility

Myocarditis.

(duration) [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Robert E. Mitchell, M. D.

Jan. 3 1930 (Address) 2151 Wilkens Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan. 4 1930

UNDERTAKER Joseph B. Cook

ADDRESS 1005 West Baltimore St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Harmison ST. 20-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Hedwig Dressler

(a) RESIDENCE No. 206 Harmison St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Rohler

(Address) 206 Harmison St.

15 FILED JAN 3 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Jan 1, 1930, that I last saw h[illegible] alive on Dec 31st, 1929, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar Meningitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Estella Henning, M. D.

1/3, 1930 (Address) 7000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Jan 4 1930

20 UNDERTAKER John M. Weber ADDRESS 401 Chester

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52636

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-01 52636

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST., 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Mills

(a) RESIDENCE NO. 2721 Bernard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Sullivan

6 DATE OF BIRTH (month, day, and year) Unknown 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
37	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer Adolphus

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible], 19[illegible] [illegible] Registrar

3-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2-30

17 I HEREBY CERTIFY, That I attended deceased from 12-19-29, 19..., to 1-2-30, 19..., that I last saw him alive on 1-2-30, 19..., and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, acute

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia - 8 days

Nephritis, acute (duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. Path.

(Signed) Marvin M. McLean, M. D.

1-3, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Lawn

DATE OF BURIAL 1/6 1930

20 UNDERTAKER L. A. Fisher & Sons

ADDRESS 131 S. Eighth

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52637

CERTIFICATE OF DEATH

90 E 52637

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 4102 Falls Rd ST.) (WARD) 13-57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David C. Snyder

(a) RESIDENCE NO. 4102 Falls Rd. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary H. Snyder

6 DATE OF BIRTH (month, day, and year) Nov. 12/1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick co. Md.

PARENTS

10 NAME OF FATHER William Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick co. Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick, co. Md.

14 Informant Mary H. Snyder (Wife)
(Address) 4102 Falls Rd.

15 Filed JAN 4 - 1930 By HAMPSON JONES, M. D. Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2/1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1929, to January 2, 1930, that I last saw h[illegible] alive on January 2, 1930 and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

a. Cardiac Dilatation

b. Hypostatic Congestion

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Hypocarditis Arteriosclerosis Pulmonum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. H. Martin 4037 Falls Road, M. D.

Jan 3, 1930 (Address) 4411 Atwood Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 1/6/1930

20 UNDERTAKER J. Walter Davis — ADDRESS 3307 Paine St

Spec.—2-29-28—L. F. S.—500 Blks.

E 52638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 52638

1—PLACE OF DEATH

REGISTERED NO. 15-59

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Delvon Bailey

(a) RESIDENCE NO. 1639 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 21, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	7	12d	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Lover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Carrie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Carrie Bailey
(Address) 1639 N. Carey St.

15 Filed JAN 4 1930 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 2, 1930, that I last saw h.er alive on Jan 2, 1930 and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) 0 yrs. 0 mos. 9 ds.

18 Where was disease contracted if not at place of death? 1639 N. Carey St. —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal puncture + autopsy

(Signed) Addison Craft Irby, M. D.

1-2, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 4 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Eastern Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52639 90 E 52639

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1700 W La Fayette St., 16-22 Ward)

2-FULL NAME Isaac A Evans

(a) RESIDENCE NO. 1700 W La Fayette St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne,

6 DATE OF BIRTH (month, day, and year): Nov 5-1858

7 AGE: Years 71 | Months 9 | Days 27 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Meat dealer
(b) General nature of industry, business, or establishment in which employed (or employer): O
(c) Name of employer

9 BIRTHPLACE (city or town): Calvert Co Md.
(State or country)

PARENTS

10 NAME OF FATHER: Richard Evans

11 BIRTHPLACE OF FATHER (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Rachel Justice

13 BIRTHPLACE OF MOTHER (city or town): Calvert Co
(State or country): Md

14 Informant: Annie Evans
(Address): 1700 W. La Fayette

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

Dec 4 - 1930

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) ..... M. D.

(Address) ..... Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Jan 5 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 130 Eastern Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52640 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 52640

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH St. Agnes. Hospital

CITY OF BALTIMORE: (No. Calon & Wilkens Aves ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hopper.

(a) RESIDENCE NO. 1304 Homewood Ave. ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) [redacted]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Thos J. Hopper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Castlegarth Va

14 Informant Mary A. Hopper. (Address) 1304 Homewood Ave

15 [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-3- 1930

17

I HEREBY CERTIFY, That I attended deceased from 1-2 , 1930 . to 1-3 . 1930.

that I last saw him alive on 1-3 , 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. mos ds.

CONTRIBUTORY [redacted]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Breen M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL New Cathedral

DATE OF BURIAL Jan 6 1930

20 UNDERTAKER Homewood Bros

ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4 - 1930

Cor.—10-10-29—A Co.—100 Bks.

E 52641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 52641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 165 Edwin St. 5-8 Ward)

2-FULL NAME Jos. Johnson

(a) RESIDENCE NO. 165 Edwin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Viola Thrasher
(Address) 165 Edwin St

15 Filed 1930 C. H. THOMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Phillips Conner, M. D.

Jan 3, 1930 (Address) 1629 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 1-5 1930

20 UNDERTAKER Byron & Knight

ADDRESS 1218 McElderry St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N4

Cor.—10-10-29—A Co.—100 Bks.

Mary E. Singer

L 52642

HEALTH DEPARTMENT—CITY OF BALTIMORE

180-001

E 52642

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1221 N. Potomac St., 8-11 Ward)

2-FULL NAME Mary E. Singer

(a) **RESIDENCE NO.** 1221 N. Potomac St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23/29

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	11 10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Singer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mable Dorsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant John Singer
(Address) 1221 N. Potomac St

15 Filed 19 C. HAMPSON JOHNSTON Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Suffocation (in bed)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Green, M. D.

1/3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 4 1930
20 UNDERTAKER	**ADDRESS**
Frank A. Fink	916 N. Gay

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N4 - 1930 -

Spec.—12-9-25—A Co.—200 Bks.

E 52643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 52643

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1229 N Caroline St. 8-13 Ward)

2-FULL NAME John R. Wright

(a) RESIDENCE NO. 1229 N Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wright

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rigger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington

(State or country) Del.

PARENTS

10 NAME OF FATHER Dustas Wright

11 BIRTHPLACE OF FATHER (city or town) Wilmington

(State or country) Del.

12 MAIDEN NAME OF MOTHER Sarah Righter

13 BIRTHPLACE OF MOTHER (city or town) Wilmington

(State or country) Del.

14 Informant Elizabeth Wright

(Address) 1229 N Caroline St.

15 Filed ..... G. HAMPSON JONES, M. D. Registrar

N 4 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 1st 1930

16 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1929, to Jan 1st, 1930, that I last saw h.... alive on Jan 1st, 1930 and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Tankin, M. D.

, 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

National Cemt. 1/4/30 1930

20 UNDERTAKER ADDRESS

Robert J. Turner 1442 N. Bdwy.

IMPORTANT. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52644 38 E 52644

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Lee

(a) RESIDENCE NO. 519 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	Blk.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
40.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Baltimore City Hospitals
(Address)

15 Filed 1-4-1930, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1929, to Jan 1. 1930.

that I last saw him alive on Dec. 31 1929

and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia
Senile

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pr Cirrhosis Liver
Senile Alcohol

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) John H. Timmis M. D.

1/4, 19 30 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cem	Jan 4 19 30
20 UNDERTAKER Samuel Hemsley	ADDRESS Md

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52645

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Gold ST. 14-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Lee

(a) RESIDENCE NO. 505 Gold ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Irene Brown

(Address) 505 Gold St

15 Filed 1-4-1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2/30

17 I HEREBY CERTIFY, That I attended deceased from 5-15-, 1929, to 1-2, 1930, that I last saw h[illegible] alive on 12-31, 1929 and that death occurred, on the date stated above, at 12 55 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Hargill, M. D.

1-4-, 1930 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	January 4-30
20 UNDERTAKER	ADDRESS
Arnold Hawley	1 Bridle

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52646

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 E. North ave ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Heard.

(a) RESIDENCE NO. 1808 E. North ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of late John W. Heard.

6 DATE OF BIRTH (month, day, and year) Dec 3rd 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Barbara Kunard

(Address) 1808 E. North ave.

15

Filed JAN 4 1930 THOMAS JONES M. D. Registrar

4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1929

17

I HEREBY CERTIFY, That I attended deceased from December 26, 1929, to December 31, 1929, that I last saw h.er alive on December 31, 1929 and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis
Arterial hypertension

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza & Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Wm. R. Bowers M. D.

1/2, 1930 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 4th 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc	4033 Woodstock

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52647

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52647

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1818 N. Eulaski St. ST., 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Grossman

(a) RESIDENCE NO 1818 N. Eulaski St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Grossman

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Grossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie —

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

13 Informant Ben Grossman

(Address) 1818 N. Eulaski St

15 Filed JAN 4 - 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929 to Jan. 3, 1929 that I last saw her alive on Jan. 2, 1929 and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-vascular-renal Disease

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Allen Grossman M. D.

, 19 (Address) 2340 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herbert Herring Run

DATE OF BURIAL 1/5 1930

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

Important. See instructions on back of certificates.

Cor.—10-10-28—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 52648

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 513 W. Barre St. 27-30 Ward)

2-FULL NAME Shirley White. (C)

(a) RESIDENCE NO. 513 W. Barre St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 28 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 10, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particulac kind of work None.
(b) General nature of industry, business, or establishment in which employed (oc employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Irwin White. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 ~~MOTHER~~ NAME OF MOTHER Evelyn Smith. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Infocmant Evelyn Smith. (C) mother.
(Address) 513 W. Barre St.

15 Filed JAN 4 1930 J. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1930. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia.
unknown.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto H. Reinhardt M. D.
1/3 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary County

DATE OF BURIAL 1/4 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1334 W Baltimore St.

Filed JAN 4 1930

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks. Time of burial extended to Jan 4, 30

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52649

CERTIFICATE OF DEATH

12 9 E 52649

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 742 W Franklin ST. (WARD) 17-16

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Jane

(a) RESIDENCE NO. 742 W Franklin ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	widow

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Willy James

6 DATE OF BIRTH (month, day, and year) Sept 22, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44	45	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer 0/0

9 BIRTHPLACE (city or town) Greensboro, (State or country) N. C.

PARENTS

10 NAME OF FATHER Thomas Sowell

11 BIRTHPLACE OF FATHER (city or town) Greensboro (State or country) N.C.

12 MAIDEN NAME OF MOTHER Henrietta Sowell

13 BIRTHPLACE OF MOTHER (city or town) Greensboro, (State or country) N. C.

14 Informant Rosabelle Brown

(Address) 742 W. Franklin St.

15 Filed JAN 4 1930, 19 CLAYTON JONES JR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 28, 1929

17 I HEREBY CERTIFY That I attended deceased from ~~Oct~~ Dec 26, 1929 to Dec 28, 1929, that I last saw h[illegible] alive on Dec 27, 1929 and that death occurred on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Glomerular nephritis

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Leslie Corbin, M. D.

19 (Address) 1717 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Macbee, S. C.

DATE OF BURIAL Jan 4, 1930

20 UNDERTAKER Mrs. Kate R Williams

ADDRESS 322 N. Schroeder St

important. See instructions on back of certificates.

Spec.—8-16-2[illegible]-L. F. S.—100 Bks.

E 52650 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 52650

46

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. 3562 Poole St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Goldie G. Keller.

(a) RESIDENCE NO. 3562 Poole St. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Keller.

6 DATE OF BIRTH (month, day, and year) March 16, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George W. Dovell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jennie E. Hepner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John T. Keller
(Address) 3562 Poole St.

15 FILED 1-4-1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to Jan 1, 1930

that I last saw h 91 alive on Jan 1, 1930

and that death occurred, on the date stated above, at 7.55 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davies, M. D.

1-3, 1930 (Address) 800 W 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Jan 6, 1930
20 UNDERTAKER	ADDRESS
Rhinewith Lon	3615 Chestnut Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52651

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 22 S. Kresson ST. (or WARD) No 37

2—FULL NAME Mary E. Long

(a) RESIDENCE NO. 22 S. Kresson ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed or divorced (HUSBAND of) (or) WIFE of: late James E. Long

6 DATE OF BIRTH (month, day, and year): Aug 15 1873

7 AGE — Years: 56 | Months: 4 | Days: 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: at Home

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Hannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Kate Devaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Agnes Hudak

(Address) 22 S. Kresson St

15 Filed 4-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1929 to Jan 3 1930

that I last saw h[illegible] alive on Jan 2 1930

and that death occurred, on the date stated above, at 10 50 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1-3-1930 (Address) 501 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 1/6 1930

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52652

CERTIFICATE OF DEATH

74 001 E 52652

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3901 Chesley Ave ST. 27-42 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Voyts

(a) RESIDENCE NO. 3901 Chesley Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Emma J. Voyts

6 DATE OF BIRTH (month, day, and year) Dec 29/64

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm Voyts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Mary Berkeley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Emma J. Voyts
(Address) 3901 Chesley ave

15 Filed 1-4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Jany 3, 1930 that I last saw h~~im~~ alive on Jany 2, 1930 and that death occurred, on the date stated above, at 9 00 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Arteri-Sclerosis A number of years.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

1/4 1930 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Schwartzbem	Jan. 5 1930
20 UNDERTAKER Philip Henrig	ADDRESS 2016 Orleans st

Important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 52653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52653

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Ashland Ave. 10-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgiana Bryan

(a) RESIDENCE NO. 1410 Ashland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	C.	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Bryan.

6 DATE OF BIRTH (month, day, and year) Unknown 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Hampton Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Harriett Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Georgie Bryan

(Address) 1410 Ashland ave.

15 Filed 4 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Dec 31, 1929, that I last saw her alive on Dec 31, 1929, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cariac Valvular disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Thomas, M. D.

1-4, 1929 (Address) 822 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn.

DATE OF BURIAL June 5th 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Ashland Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 52654

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 W. 27th ST., 9-46 WARD)

2—FULL NAME Emma Edwards Roper

(a) RESIDENCE NO. 23 W. 27th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L. Roper

6 DATE OF BIRTH (month, day, and year): Nov. 22, 1846

7 AGE — Years: 83 | Months: 1 | Days: 12 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Petersburg Va

PARENTS

10 NAME OF FATHER: Samuel Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Petersburg Va

12 MAIDEN NAME OF MOTHER: Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mr. Wallace R. Roper

(Address) 6311 Winner Ave.

15 Filed 4-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 1927, to Jan. 3, 1930, that I last saw ~~him~~ her alive on January 2, 1930 and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Geo. M. Gaehle, M. D.

1/3, 1930 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Jan. 4 1930

20 UNDERTAKER: W. M. Puckett Son ADDRESS: North & Pa

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52655

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Bentalou ST. 16-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Edward Bailey

(a) RESIDENCE NO. 831 Bentalou ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Jane McKee

6 DATE OF BIRTH (month, day, and year) Nov. 13-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (retired)

(b) General nature of industry, business, or establishment in which employed (or employer) as above

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Worcester Co. Md

PARENTS

10 NAME OF FATHER Robert E. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Worcester Co. Md

12 MAIDEN NAME OF MOTHER Mary Shockley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Worcester Co. Md

14 Grandson Informant Walton Edward Hayman

(Address) 1 E. Ruxton Ave & Beverly Blvd Lutherville Harford Co. Md

15 Filed JAN 4 - 1930, 19.. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-3-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 3, 1930, that I last saw him alive on Jan 3, 1930, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Jno S. Bishop, M. D.

1-4-1930 (Address) 122-25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury Md — DATE OF BURIAL 1-4 1930

20 UNDERTAKER Samuel Fooks — ADDRESS 916 Pine

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52656

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N Arlington St., 16-N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Hall.

(a) RESIDENCE NO. 312 N Arlington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	Wid.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Daisy Haywood

(Address) 314 N Arlington

15 Filed 4-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 19 29, to Jan 3, 19 30

that I last saw her alive on Jan 2, 19 30

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Mammary Carcinoma

(duration) yrs. 3? mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Liver

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

Jan 3 19 30 (Address) 937 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Ceme	1-4 1930

20 UNDERTAKER Leland Eaton Sons

ADDRESS 916

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 47 E 52657

1—PLACE OF DEATH Hospital for the Women of Maryland REGISTERED NO.

CITY OF BALTIMORE: (No. Lafayette and Linden ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Dorris Elmayer Sandruck

(a) RESIDENCE NO. 843 Arlington Road, York St., Pa. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. 13 How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abram Sandruck

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1866

7 AGE	63 Years	2 Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Nathan Elmayer

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Rosa Sauer

13 BIRTHPLACE OF MOTHER (city or town) Wilkes-Barre
(State or country) Pennsylvania

14 Informant Mrs Sandruck Married Daughter
(Address) 843 Arlington St. York Pa

15 Filed 1930, 19 H. M. JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—4—30

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1929, to January 4, 1930, that I last saw him alive on January 4, 1930 and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earle P. Clawson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pennsylvania

DATE OF BURIAL 1/6 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

Spec.—8-16-29—L. F. S.—100 Bks.

232496 E 52658

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52658

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C. Jones

(a) RESIDENCE NO. Sistersville W. Va ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. mos. 11 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) Jan-22-59

7 AGE Years	Months	Days 12	If LESS than 1 day, ... hrs. or ..... min.
70	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Oil Operator

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Mary Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 1930 C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-4-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 4, 1930, that I last saw h.. alive on Jan 4, 1930 and that death occurred, on the date stated above, at 235 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Broncho

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate & metastasis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) H. C. Smith, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sistersville W. Va. DATE OF BURIAL Jan. 4 1930

20 UNDERTAKER Harry H. Witsle ADDRESS 4101 Edmondson Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

197 E 52659

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St. 16-22 Ward)

2-FULL NAME Reuben Heyman

(a) RESIDENCE NO. 1197 N. Fulton Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country) Md

PARENTS

10 NAME OF FATHER Solomon Heyman

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country) Russia

12 MAIDEN NAME OF MOTHER Ada Samuelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Solomon Heyman
(Address) 1197 N. Fulton Ave

15 Filed JAN 5 1930 Harrison Jones M D Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound - through the Right Chest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Norris, M. D.

1/4 1930 (Address) 3632 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herman Rm

DATE OF BURIAL 1/5 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eldale Ave

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 52660

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Rutland & Monument Ave. (Ward) 15-58

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rickie Horwitz

(a) RESIDENCE NO. 2315 Wichita Ave., ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Horwitz deceased

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	76	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Abraham Balisok
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Montan
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant S. N. Feeidel
(Address) 2010 Wichita ave

15 Filed JAN 5 1930 G. Hall Jones, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/ 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/1/ 1930, to 1/4/ 1930,
that I last saw h[illegible] alive on 1/4/ 1930,
and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:
Broncho. pneumonia

(duration) .. yrs. .. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) .. yrs. .. mos. .. ds.

18 Where was disease contracted if not at place of death? At home.
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) B. J. Cohen, M. D.
1/4, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rem. DATE OF BURIAL 1/5 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 52661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 52661

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 507 N. Belnord Ave

CITY OF BALTIMORE: (No.....) ST., 7-10 (WARD)

2-FULL NAME Henry Anton Mohr.

(a) RESIDENCE NO. 507 N. Belnord Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? — yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catharine Mohr

6 DATE OF BIRTH (month, day, and year) June 6, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none at present

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Mohr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Robert Mohr

(Address) 507 N. Belnord Ave

15 Filed JAN 5 - 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1930

17

I HEREBY CERTIFY, That I attended deceased from June 9, 1928, to Jan. 3, 1930,

that I last saw him alive on Jan. 2, 1930

and that death occurred, on the date stated above, at 5:05 P m.

The CAUSE OF DEATH* was as follows:

Carditis

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) nephritis, hypertension and

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 6/21/29 Prostatectomy

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) L. C. Sobilad M. D.

1/3, 1930 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cemetery — DATE OF BURIAL Jan 6th 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Isabelle H. Plummer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52662

CERTIFICATE OF DEATH.

44 E 52662

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 E 27th ST. 1-1 WARD)

2-FULL NAME Isabelle H. Plummer

(a) RESIDENCE NO. 1122 S. East Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James N. Plummer

6 DATE OF BIRTH (month, day, and year) Feb 12/1353

7 AGE	Years	Months	Days 21	If LESS than 1 day, ...hrs. or ....min.
	71	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Staunton, Va

PARENTS

10 NAME OF FATHER James T. Greaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Staunton, Va

12 MAIDEN NAME OF MOTHER Rebecca Bright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Staunton, Va

14 Informant Della Callahan (sister)

(Address) 427 E 27th St

15 Filed JAN 5 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 19 29, to Jan 3/30, 19, that I last saw her alive on Jan 3/30, 19, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach & liver

(duration) 2? yrs. mos ds.

CONTRIBUTORY (Secondary) Ventral Hernia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carter M. D.

(Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 1/6/1930

20 UNDERTAKER Wm Cook — ADDRESS 127 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52663

49 V

CERTIFICATE OF DEATH

REGISTERED NO. E 52663

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Heath

(a) RESIDENCE NO. 137 Requith ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 37

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Mary land

PARENTS

10 NAME OF FATHER Conrad Frisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Hospital Record.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-4-30

17 I HEREBY CERTIFY, That I attended deceased from 12-12, 1929, to 1-4, 1930, that I last saw h[illegible] alive on 1-4, 1930 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Abdomen

(duration) Unknown

CONTRIBUTORY (Secondary) Secondary Anemia & Bronchopneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Thompkins, M. D.

1-4, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 7th 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 52664

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 27-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Collenberg

(a) RESIDENCE NO. 4128 E. Hamilton Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0.37

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Pete Herrmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record

(Address)

15 Filed JAN 5 - 1930 WM. F. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-4-30

17 I HEREBY CERTIFY, That I attended deceased from 12-28, 1929, to 1-4, 1930, that I last saw h.. alive on 1-4, 1930 and that death occurred, on the date stated above, at 4:00 p. m.

The CAUSE OF DEATH* was as follows:

Generalized atherosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. W. Lumpkin, M. D.

1-4, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 7th 1930
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul st

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 E 52665

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves (ST.) 70-64 (WARD)

2-FULL NAME Gladys A Roberts

(a) RESIDENCE NO. 2704 W Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 23 / 1903

7 AGE — Years: 26 — Months: 9 — Days: 7 40 11

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James A. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillie C. Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Lillie C. Lehnhoff 2704 W. Franklin

15 Filed JAN 5 - 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1930

17

I HEREBY CERTIFY, That I attended deceased from 12-29, 1929, to 1-3, 1930,

that I last saw her alive on 1-3, 1930,

and that death occurred, on the date stated above, at 3.45 A m.

The CAUSE OF DEATH* was as follows:

Infected Ovarian Cyst

(duration) yrs. 3 mos [illegible] ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes Date of Jan 2 30

Was there an autopsy? [illegible]

What test confirmed diagnosis? Removal of Cyst

(Signed) Ernest Spencer Jr., M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem

DATE OF BURIAL: 1/6, 1930

20 UNDERTAKER: Geo Weber & Son 2503 Edmondson

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52666

CERTIFICATE OF DEATH

Dr Kahn
2 15 52666

47

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2240 Mrs Baltimore ST., 20-C WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME M. Elizabeth Regus

(a) RESIDENCE NO. 2240 Mrs Baltimore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of The late George Regus

6 DATE OF BIRTH (month, day, and year) June 10/1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer Self Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Adam Gettmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) /

12 MAIDEN NAME OF MOTHER /

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Milton L. Regus

(Address) 5319 Bristol Avenue

15 Filed 1930 Registrar

Important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 31st, 1929, to Jan 3rd, 1930

that I last saw her alive on Jan 3rd, 1930

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast with Metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam

(Signed) Chas A Cain, M. D.

1/4, 1930 (Address) 2105 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	1/6/1930

20 UNDERTAKER Geo. Weber & Son ADDRESS 3503 Edmondson

AUG - 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52667

CERTIFICATE OF DEATH.

1119 E 52667

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Redwood St. 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louden

(a) RESIDENCE NO. 628 Redwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Stephen Lewis

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Rebecca Baker
(Address) 628 Redwood

15 Filed JAN 5 - 1930, 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Jan 2, 1930,

that I last saw her alive on Jan 1, 1930

and that death occurred, on the date stated above, at 5:30 P m

The CAUSE OF DEATH* was as follows:

Ulceration of Rectum

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Nov 28

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R B Kenyon, M. D.

Jan. 19 30 (Address) 601 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 5 19 30
20 UNDERTAKER	ADDRESS
Samuel Bowers	Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52668

CERTIFICATE OF DEATH

38

E 52668

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 13-5 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Robinson

(a) RESIDENCE NO. 2418 Madison Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant Records of

(Address) Balto. City Hospitals

15 Filed JAN 5 1930, 19 HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2-30

17

I HEREBY CERTIFY, That I attended deceased from 12-18-29, 19..., to 1-2-30, 19...,

that I last saw him alive on 1-2-30, 19...

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of Central Nervous System

(duration) ...yrs. over 2 mos. ...ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ...yrs. ...mos. 2 ds.

18 Where was disease contracted if not at place of death? Home Fever

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wass. & C.S.F. Lab

(Signed) Marvin M. Wilson, M. D.

1-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cem.	January 19 30
20 UNDERTAKER Emmert & Nemsley	ADDRESS 578 Dallas St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52669

CERTIFICATE OF DEATH

75-002 E 52669

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital Ward) 22-30

2-FULL NAME Abraham L. Bell

(a) RESIDENCE NO. 526 Eutaw St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
28	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Henry Bell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Elinor Bell
(Address) 725 Hanover St

15 Filed JAN 6 1930, 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. J. Chesney M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1-5 1930

20 UNDERTAKER Samuel Carlson — ADDRESS 816 Bway

JAN 6 1930

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52670

CERTIFICATE OF DEATH

90 ✓ E 52670

REGISTERED NO. 13-56

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3445 Chestnut Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura E. Duvall.

(a) RESIDENCE NO. 3445 Chestnut Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Thomas B. Duvall.

6 DATE OF BIRTH (month, day, and year) July 12, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	5 6	21 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER George W. Sherwood.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Wells.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14

Informant Mary F. Yeagle.

(Address) 3445 Chestnut Ave.

15

Filed JAN 5 1930, 19 H. W. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4, 1930.

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Jan 4, 1930, that I last saw h[illegible] alive on Jan 3, 1930 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiac Disease

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

Jan 4, 1930 (Address) 3424 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden.	Jan 6, 1930
20 UNDERTAKER Edmonds Son	ADDRESS 3617 Chestnut Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52671 90 E 52671

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 Eisquith ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Bull

(a) RESIDENCE NO. 1815 Eisquith ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard E. Bull

6 DATE OF BIRTH (month, day, and year) March 4 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Patrick Mulligan

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country) Md. Va.

12 MAIDEN NAME OF MOTHER M. Mulligan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Howard E Bull

(Address) 1815 Eisquith St

Filed JAN 5 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN-2-1930

17 I HEREBY CERTIFY, That I attended deceased from JAN 10 1928, to JAN 2- 1930, that I last saw h.i.m. alive on JAN 2- 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? at Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Alott Duker M. D.

JAN 4 1930 (Address) 928 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn Cemtery. DATE OF BURIAL 1/6 1930

20 UNDERTAKER George J Ruth 1735 ADDRESS Hanford Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52672

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 N. Central ave. 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael J. Mc Coy.

(a) RESIDENCE NO. 1419 N Central ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Mc Coy.

6 DATE OF BIRTH (month, day, and year) June 30/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work W. T.

(b) General nature of industry, business, or establishment in which employed (or employer) Lit Bag

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Mc Coy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER D. Conlon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary L. Mc Coy.

(Address) 1419 N. Central Ave

15 Filed JAN 5 1930, 19 ELMER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Jan 3, 1930, that I last saw him alive on Jan 2, 1930 and that death occurred, on the date stated above, at 1-40 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Bill Hall, M. D.

Jan 5. 1930 (Address) 1631 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Jan. 6 1930

20 UNDERTAKER George J. Rust ADDRESS 1735 Hayford ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 E 52673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 N. Glover ST.) 6-10 (WARD)

2—FULL NAME Melvin J. Dyer

(a) RESIDENCE NO. 200 N. Glover ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	14	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence B. Dyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian L. Reese

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14

Informant Clarence B. Dyer

(Address) 200 N. Glover St.

15

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 - 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Jan 4, 1930, that I last saw h... alive on Jan 3, 1930, and that death occurred, on the date stated above, at 8 00 H m.

The CAUSE OF DEATH* was as follows:

Marasmus

CONTRIBUTORY (Secondary) Exhaustion (duration) ... yrs. ... mos. 7 ds.

... (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Cook M. D.

1/4, 1930 (Address) 413 N Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Baltimore Cemetery	Jan. 6 1930

20 UNDERTAKER

ADDRESS

Wm. H. Miller & Son 2354 Jefferson St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 52674

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2738 E. Baltimore ST. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida M Bosse

(a) RESIDENCE NO. 2738 E. Baltimore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 24-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry M Bosse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Dora Fleckenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry M Bosse
(Address) 2738 E. Baltimore St

15 Filed JAN 5 1930 WILLIAM JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1930

17 I HEREBY CERTIFY That I attended deceased from July 24, 1929 to Jan. 3, 1930, that I last saw h[illegible] alive on Jan. 3 1930 and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation, due to dilatation

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 6 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. S. Hayden, M. D.

1/4 1930 (Address) 1216 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Jan 6 1930

20 UNDERTAKER Wm C. Miller & Son

ADDRESS 2634 Jefferson St

Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 52675

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52675

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Wright

(a) RESIDENCE NO. 23 N. Montford Ave St. Ward

(Usual place of abode) 40

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Wright

6 DATE OF BIRTH (month, day, and year) April 14 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	66	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 0 10

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New Jersey

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (City or town)

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Martha Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Jersey

14 Informant Hospital Records.

(Address)

JAN 5 - 1930 HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Jan. 2, 1930

that I last saw h alive on Jan 2, 1930

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Hypertension, Chronic Diffuse Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. Thompson M. D.

1/3/30. 19 (Address) 1 N Hoppkins Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

London Park Cemetery Jan 6 1930

20 UNDERTAKER — ADDRESS

Mrs C Miller & Son 2334 Jeffers St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52676

CERTIFICATE OF DEATH.

100-001

E 52676

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument + Rutland Ave ST.) 2332 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milvia John

(a) RESIDENCE NO. 1915 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dan

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Costa John.

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Theresa —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Costa John

(Address) 1857 Ohio St Phila Pa

15- AN 5 Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4 1930.

17 I HEREBY CERTIFY, That I attended deceased from 1-4 .1930. to 1-4 .1930.

that I last saw h[illegible] alive on 1-4 .1930.,

and that death occurred, on the date stated above, at 11:55 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel J. Kaufman M. D.

, 19 (Address) J Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

DATE OF BURIAL 1-5 1930

20 UNDERTAKER Byron & Wright

ADDRESS 1218 McCulloh St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

232180

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52677

CERTIFICATE OF DEATH

57

E 52677

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 3-5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dominick Carozza

(a) RESIDENCE NO. 701 Albemarle ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia

6 DATE OF BIRTH (month, day, and year) June 3 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cane - [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records—

(Address) .....

15 Filed JAN 5 1930, 19.... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 6- ....., 1929, to Jan 3, 1930, that I last saw h alive on Jan 3, 1930, and that death occurred, on the date stated above, at 4:15 p m.

The CAUSE OF DEATH* was as follows:

Intoxication associated with gas gangrene (B. welchii)

..... (duration) ..... yrs. ..... mos. 9 da.

CONTRIBUTORY (Secondary) Pneumonia (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 12/24/29 Leg amputation

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) I. R. Diveny Trimble, M. D.

Jan 4. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 6 1930

20 UNDERTAKER M. Dr. E. Deppe ADDRESS 21 L Conn Av

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52678 ✓ E 52678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52678

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Linden ave ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gretchen L Wolff

(a) RESIDENCE NO. 1118 Linden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur L Wolff

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kerr

(Address) 1118 Lindenave

15 JAN 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3, 30

17 I HEREBY CERTIFY, That I attended deceased from November 23, 1929, to January 3, 1930, that I last saw h alive on January 3, 1930, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease and chronic interstitial nephritis

(duration) over 8 years. yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test.

(Signed) C Henry C Obbe M. D.

1-3, 1930 (Address) 1202 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn cemetery	Jan 6 1930
20 UNDERTAKER	ADDRESS
W Marvin Routson	2238 W Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52679

CERTIFICATE OF DEATH

129 ✓ E 52679

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3707 Parkside Drive ST., Dec 44 WARD)

2—FULL NAME Calvin Gerard Chesnut

(a) RESIDENCE NO. 3707 Parkside Drive ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Chesnut.

6 DATE OF BIRTH (month, day, and year) Feb 10, 1856

7 AGE	Years	Months	Days 23	If LESS than 1 day, hrs. or min.
	73	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. old

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Gerard S. Chesnut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington Del.

12 MAIDEN NAME OF MOTHER Susan Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Gerard S. Chesnut

(Address) 3707 Parkside Drive.

15 Filed JAN 6 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Jan. 3, 1930, that I last saw h[illegible] alive on Jan. 2, 1930 and that death occurred, on the date stated above, at 10.55a m.

The CAUSE OF DEATH* was as follows:

Cbr nephritis
Hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insuff

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P E & Lab

(Signed) Homer L. Todd, M. D.

1/4 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Jan 6 1930
20 UNDERTAKER Wm Mickel Sons	ADDRESS North Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 52680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52680

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST. (WARD)

2-FULL NAME Mrs. Ella Nora Keller

(a) RESIDENCE No. 1164 Atwood Rd. Philadelphia Penna.
(Usual place of abode) ST. WARD

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Keller

6 DATE OF BIRTH (month, day, and year) Dec 26 1862

7 AGE	Years	Months	Days
	67	0	10

If LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jeffiers

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna Maria Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. E. N. Keller
(Address) 1164 Atwood Rd. Phila. Pa.

15 [illegible] JONES, M. D.
Registrar

JAN 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1930 to Jan 5 1930,
that I last saw h[illegible] alive on Jan. 5 1930
and that death occurred, on the date stated above, at 11-30 a m
The CAUSE OF DEATH* was as follows:

Chronic Glomerulo-nephritis

(duration) ! yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) G. V. Castagna, M. D.

(Address) W. Balto. Pa. 6-30.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Jan 6 1930

20 UNDERTAKER J. J. Tucker & Sons ADDRESS Phila Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52681

1—PLACE OF DEATH

CERTIFICATE OF DEATH

1929 E 52681

REGISTERED NO.

CITY OF BALTIMORE: (No. 306 Presstman ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Tibbs

(a) RESIDENCE NO. 306 Presstman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
62	6	5-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 67

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Tibbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Estella Cook

(Address) 306 Presstman

15 Filed JAN 6 1930, 19 C. H. Lee Registrar

Reg. 1806

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 1, 19 29 to January 2, 19 30, that I last saw her alive on January 2, 19 30 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Interstitial

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Edema of the Lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. O'Neill, M. D.

19 (Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL 1/6/30

20 UNDERTAKER Mrs. Geo. E. Hollan — ADDRESS 1831 Druid Hill

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52682

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 1724 90

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse Freeman

(a) RESIDENCE NO. 543 Orchard ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	~~Unknown~~ M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Unknown~~ Annie Freeman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Md.~~ N.C.

PARENTS

10 NAME OF FATHER Alfred Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Lucy Wheatley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed JAN 6 1930 CRAWFORD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2-30

17 I HEREBY CERTIFY, That I attended deceased from 12-28-29, 19..., to 1-2-30, 19..., that I last saw him alive on 1-2-30, 19..., and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Tacute

about 1 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over 1 (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Past: P.E.

(Signed) Warren W. McLean, M. D.

1-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Auburn — DATE OF BURIAL Jan 6 1930

20 UNDERTAKER Sam'l M. Chase & Son — ADDRESS 1400 Mosher

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52683

CERTIFICATE OF DEATH.

E 52683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3310 Elm. Ave. ST. 13 52 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L Farr.

(a) RESIDENCE No. 3210 Elm. Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ Eva M. Farr

6 DATE OF BIRTH (month, day, and year) Feb. 29. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10.	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Rigger

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer C. J. Benson.

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Leonard Farr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Helene Berlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Eva M. Farr. (Wife)

(Address) 3310 Elm Ave.

15 Filed ....., 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-5- 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Jan 4, 1930, that I last saw h[illegible]live on Jan 4, 1930, and that death occurred, on the date stated above, at 5 30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J Darker, M. D.

1-5. 1930 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore [illegible] DATE OF BURIAL Jan. 7, 1930

20 UNDERTAKER J. Walter Davis ADDRESS 330 N. Paine St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 52684

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument St. 610 (WARD)

2-FULL NAME Israel Caplan

(a) RESIDENCE NO. 4 N. Collington Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Caplan

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Caplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Tara —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Chas. Caplan

(Address) 4 N. Collington Ave

15 Filed 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930, to Jan 5, 1930, that I last saw him alive on Jan 5, 1930, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Chr. valvular heart disease (Mitral Insufficiency)

c Cholelithiasis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. nephritis

weeks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Jacob H. Conn M. D.

1/5, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebrew Herzog Rm

DATE OF BURIAL 1-6-30

20 UNDERTAKER Jack Levin

ADDRESS 1479 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Morris Marcus

E 52685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52685

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 16-16 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rabbi Morris Marcus

(a) RESIDENCE NO. 1002 W. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elda Rose Marcus

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 42; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rabbi

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Levis

(Address) 1439 E Balto St

15 Filed JAN 6 - 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 5, 1930, that I last saw h alive on Jan 5, 1930, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Data

(Signed) C. Heiman M. D.

1/5, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery DATE OF BURIAL 1/6 1930

20 UNDERTAKER: Jack Levis ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52686 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 52686

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Sarah Ann St. 16 WARD)

2-FULL NAME Elderga Chambers

(a) RESIDENCE NO. Life 706 Sarah Ann ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9, 1929

7 AGE — Years | 3 Months | 26 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER David Chambers

11 BIRTHPLACE OF FATHER (city or town) N. Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Brooks

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Carrie Williams
(Address) 706 Sarah Ann St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to Jan 4, 1930, that I last saw her alive on Jan 3, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH was as follows:

Hereditary Lues

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Howell M. D.

1/4, 1930 (Address) 1621 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Jan. 6, 1930

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 3227 Edmondson Ave

CAUSE OF DEATH to be filled in by physician, so that it may be properly classified. EACH statement of symptoms TION is very important. See instructions on back of certificates.

JAN 6 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 52687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1/2 E 52687.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 N Lanvale ST. 1-2-4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Wells

(a) RESIDENCE NO. 620 N. Lanvale ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Wells

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jacksonville, Fla

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sarah E. Wells

(Address) 620 W. Lanvale St

15 Filed JAN 6 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Jan 2, 1930, that I last saw him alive on Jan 1, 1930 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) 1 yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms + Test

(Signed) Thos J Woolley Jr M. D.

1-4 1930 (Address) 1703 N Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Jan 6, 1930

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

IMPORTANT.—See instructions on back of certificates. Exact statement of OCCUPATION is very important. If DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

Edward Yarbrough

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52688

CERTIFICATE OF DEATH

179 E 52688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St., 16-26 Ward)

2-FULL NAME Ed Yarbrough

(a) RESIDENCE NO. 961 Bennett Place St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jack Yarbrough

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Clara Hill

13 BIRTHPLACE OF MOTHER (city or town) S C.
(State or country)

14 Informant Clara Hill
(Address) 961 Bennett Place

Filed JAN 6 1930, 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Burns over body
Burns after from oil stove
accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas H Brooke M. D.
Jan. 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1-6 1930

20 UNDERTAKER Mrs Katie R Williams — ADDRESS 322 Schroeder

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

B 52689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1299 ✓ E 52689

REGISTERED NO. 95-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4127 Parkwright Ave ST., (13th WARD)

2—FULL NAME John A. Barker

(a) RESIDENCE NO. 4127 Parkwright Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence L Barker

6 DATE OF BIRTH (month, day, and year) Mar 4-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Conductor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cleveland Ohio

PARENTS

10 NAME OF FATHER Wm Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass,

12 MAIDEN NAME OF MOTHER Harriet Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs Florence L Barker
(Address) 4127 Parkwright Ave

15 Filed JAN 6 - 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1-, 1929, to Jan 4, 1930,
that I last saw him alive on Jan 4, 1930
and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous
Nephritis
Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James L. Ashelman, M. D.

(Address) 4012 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 7 1930

20 UNDERTAKER A. L. Marshall — ADDRESS 3539 Falls Road

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52690

CERTIFICATE OF DEATH

74-001

E 52690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. W. S. T. & G. Bldg St. 27-55 Ward

2-FULL NAME Louis C. Wilder

(a) RESIDENCE NO. 2600 Ken Oak Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76. 75	8 9	8 0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) 089
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Wilder

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Emma Moffitt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Mrs. Ford Shirley
(Address) 2600 Ken Oak Road

15 Filed JAN 6 1930, 19 H. J. KELLY, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central hemorrhage

London

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. T. Tuttle, M D Town

Jan. 19 30 (Address) 1659 Bway, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Jan 6 1930

20 UNDERTAKER Rita Wiedefeld

ADDRESS Fremont Ave

JAN 6 - 1930

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52691

CERTIFICATE OF DEATH

REGISTERED NO. E 52691

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5941 Falls Road ST. 21-53 WARD)

2—FULL NAME Bessie E Bryan

(a) RESIDENCE NO. 5741 Falls Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert J. Bryan

6 DATE OF BIRTH (month, day, and year) July 10-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodstock, Md

PARENTS

10 NAME OF FATHER Frank Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Albert J Bryan

(Address) 5941 Falls Road

15 Filed JAN 6 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4-1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Jan 4, 1930, that I last saw h alive on Jan 3, 1930 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Chas. W. Cousins with M. D.

1/6, 1930 (Address) 9 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan. 7 1930.

20 UNDERTAKER Horace A Burgee — ADDRESS 1631 Falls Road

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 52692

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Woodyear ST. 16-23 WARD)

2-FULL NAME Sophie Boyer

(a) RESIDENCE NO. 112 x Woodyear ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Boyer

6 DATE OF BIRTH (month, day, and year) 5 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Minnie Knox (Address) 112 Woodyear St

15 Filed JAN 6 - 1930 [illegible] JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1930 to Jan 7 1930, that I last saw her alive on Jan 3 1930, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Chronic) (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Tarr M. D.

1/6 1930 (Address) 728 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Jan 6 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

BEFORE filling this certificate, read carefully the instructions on the back. ALL questions should be answered. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Corr. 12-[illegible] 200 Bks.

E 52693

HEALTH DEPARTMENT—CITY OF BALTIMORE E 52693

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at
City of BALTIMORE: (No. Baltimore City Hospitals St., 76-31 Ward)

REGISTERED NO. 199

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Nordbruch

(a) RESIDENCE NO. 526 S. 45th Street St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) October 12, 1915

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	14	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John Nordbruch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Dzinnik

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mississippi

PARENTS

14 Informant Mrs. John Nordbruch (Mother)
(Address) 526 S. 45th St.

15 Filed JAN 6 1930, 19 [illegible] (SEAL)
Per [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Tract Skull
Was run down by hit and run
while repairing bicycle on road side
Home (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Tract. Axis & Atlas (duration) yrs. mos. ds.

1/2/31 Signed H. J. Frazier M. D.
(Coroner)
(Address) 1489 W. Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the state yrs. mos. ds.
Where was disease contracted, if not at place of death? Eastern Ave Rd - Ave Canton RR
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — Date of Burial Jan. 6, 1930

20 UNDERTAKER Henry Sander & Sons. Inc. — ADDRESS Baltimore & Broadway

Very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52694

CERTIFICATE OF DEATH

E 52694

1-PLACE OF DEATH

City of Baltimore: (No. 522 Chestnut Hill Ave. St., 9-47 Ward)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank A. Kelly

(a) RESIDENCE NO. 522 Chestnut Hill Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 6 mos. 14 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June 20, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	6	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer United Railway

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James A. Kelly

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie T. Gannon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Annie T. Kelly
(Address) 522 Chestnut Hill Ave.

15 Filed JAN 6 - 1930 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
(History of Hypertension)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/5/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 1/7 19 30

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 405 N. Calvert

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52695

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 52695

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Augusta ST., 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Hill

(a) RESIDENCE NO. 207 Augusta ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Mrs. J. G. Locks

(Address) 1302 Jefferson

15 Filed 1-6 1930, 19 C. HAMILTON JONES, M. D.

Registrar

Dep

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-4-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Jan 4 1930, that I last saw her alive on Jan 4, 1930 and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Renal Disease

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [signature], M. D.

1-6, 1930 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem.

DATE OF BURIAL: Jan. 6 1930

20 UNDERTAKER: Mrs J. G. Locks

ADDRESS: 1302 Jefferson

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 52696

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 ODonnell ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizbeth M. Kleiner nee Schifferer

(a) RESIDENCE NO. 2824 ODonnell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Kleiner

6 DATE OF BIRTH (month, day, and year) March 22 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Tinsmithing Labor

(c) Name of employer (Tinsmithing)

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Schifferer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rukey Knoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John Schifferer

(Address) 2824 ODonnell St.

15 Filed JAN 6 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem Co

DATE OF BURIAL 6 1930

20 UNDERTAKER John C. Miller

ADDRESS 2455 E Lafayette

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52697 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52697

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 ½ Streeper ST. 6-11 WARD)

2-FULL NAME Barbara Handloser

(a) RESIDENCE NO. 203 ½ Streeper ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Handloser

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79 80				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Maser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Kuehner

(Address) 203 N. Streeper St

15 Filed 1930 C. HAMILTON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 4, 1930, that I last saw h alive on Jan 4 1930 and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John T Avery, M. D.

, 19 (Address) 1603 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Jan 7 1930 DATE OF BURIAL

20 UNDERTAKER John C. Miller 2435E ADDRESS Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52698

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52698

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 E. Hoffman ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Plitt

(a) RESIDENCE NO. 2018 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (write the word)
F.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Plitt

6 DATE OF BIRTH (month, day, and year) Oct. 24 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Carson Schultze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Helena Schultze.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Chas. Plitt.

(Address) 2018 E Hoffman st

15 Filed ... 19 ... CHARLES JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/30

17 I HEREBY CERTIFY, That I attended deceased from 1/2/30, 19..., to 1/13/30, 19..., that I last saw h. Er alive on 1/13/30, 19..., and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Endocarditis, Arteriosclerosis

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard A. Kelly M. D.

19 (Address) 332 E 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy	Jan 6 1930

20 UNDERTAKER George J. Rutt ADDRESS 1735 Harford av

OF DEATH in plain terms, so that it may be properly classified. State contagious diseases. See instructions on back of certificates.

important.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52699

1—PLACE OF DEATH

REGISTERED NO. 27-55-90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5230 St Charles ave ST., 27 WARD)

2—FULL NAME Mrs. Edna A Krugman

(a) RESIDENCE NO. 5230 St Charles ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Samuel H Krugman

6 DATE OF BIRTH (month, day, and year) Aug 7. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
39		3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Urban A Eckenrode

11 BIRTHPLACE OF FATHER (city or town) Adams Co
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Anna M Kramer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Urban A Eckenrode

(Address) 5230 St Charles ave.

15 Filed JAN 6 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1930,

17 I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1929, to Jan 4, 1930.

that I last saw her alive on Jan 2, 1930

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chron. mitral Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation & Auricular Fibrillation (duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? Childhood-Rheumatism

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Emson, M. D.

1-4, 1930 (Address) 4536 Park Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 7 1930
20 UNDERTAKER	ADDRESS
Fred A. Reuss & Son	733 S. Howard

IMPORTANT. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 52700 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 E 52700

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1648 Appleton St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Henson Crum

(a) Residence No. 1648 N. Appleton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If ~~married~~, widowed, ~~or divorced~~, HUSBAND of (or) ~~WIFE of~~ Wilhelmina

6-DATE OF BIRTH (month, day and year) May 4/1871

7-AGE, 59 yrs. 6 mos. ds. LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer): 063
(c) Name of employer: 1

9-BIRTHPLACE (city or town) (State or Country): Frederick City, Md.

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): 4

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): 1

14-
(Informant) J. Crum
(Address) 1648 E. Appleton St.

15-
Filed ..... 1930 H. L. JONES, M. D.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jany 7/1930

17- I HEREBY CERTIFY, That I attended deceased from Twenty years 19.... to Jan. 19 30 that I last saw him alive on Four weeks ago 19.... and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Had attack about 2 yrs ago
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Barnett C. Gatlin M. D
19 (Address) 1404 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: Jan. 7, 1930

20-UNDERTAKER: Josiah S. Fyfer — ADDRESS: 16 W. North Ave

JAN 6 - 1930

(over)

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52701

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 218 N Amity ST., 16-26 WARD

2—FULL NAME Lucinda Boston

(a) RESIDENCE NO. 218 N. Amity ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savage Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma Jackson
(Address) 100 N. Amity

15 Filed JAN 5 - 1930 H. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to Jan 1, 1930, that I last saw h alive on Jan 1, 1930 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonic Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T J Norwood, M. D.

Jan 8/30 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 6, 1930
UNDERTAKER Mrs. Katie R Williams	ADDRESS 3221 Schroeder St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 52702

1—PLACE OF DEATH Mercy Memorial Hospital (REGISTERED NO. 27-59)

CITY OF BALTIMORE: (No. 33rd ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Florence J. Smith

(a) RESIDENCE NO. 4613 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 7 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Randolph Smith

6 DATE OF BIRTH (month, day, and year) May 26 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER James K. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Ella Conner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Hospital Records

(Address)

15 Filed JAN 6 1930 H. Riley Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Jan 5, 1930, that I last saw her alive on Jan 1, 1930 and that death occurred, on the date stated above, at 7 45 a. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis (ruptured)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) 6 yrs. 0 mos. 9 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Dec 28, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Campbell Thompson, M. D.

Jan 5, 1930 (Address) Mercy Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oxford, Pa. DATE OF BURIAL Jan 8 1930

20 UNDERTAKER Hughes Funeral Service ADDRESS 1st & Broadway

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52703

CERTIFICATE OF DEATH.

101-001

E 52703

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1067 N. Greene St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Funneran

(a) RESIDENCE NO. 1067 N. Greene St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: George Funneran

6 DATE OF BIRTH (month, day and year)

7 AGE: Years: 44 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14

Informant

(Address)

Filed JAN 6 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Edgar Feldman M. D.

(Coroner)

1/2, 1930 (Address) 709 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL. Date of Burial: JAN 6 - 1930

20 UNDERTAKER ADDRESS

Commissioner of Health

PAR MORTEM

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52704

CERTIFICATE OF DEATH

E 52704

1-PLACE OF DEATH

City of Baltimore: (No. 526 Hanover St. St., 27-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kennbol.

(a) RESIDENCE NO. 526 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	56	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 23, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Illuminating Gas Poisoning.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

1/2, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JAN 6 - 1930 Commissioner Health

THE MORGUE

4231

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 52705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

33

E 52705

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1310 W La Fayette St., 16-23 Ward)

2-FULL NAME Susie Johnson

(a) RESIDENCE NO. 1310 W La Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 Color or Race Col'd | 5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE About Years 42 Months | Days | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Prod
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N.W. Police Record
(Address)

15 Filed ..... 19.. Registrar

JAN 6 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 22 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) ...yrs. 6 mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER
(Address)

ADDRESS

JAN 6 - 1930

THE MORGUE

4232

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52706 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 52706

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 26-38 Ward)

2-FULL NAME Ernest Wilson

(a) RESIDENCE NO. Phila Rd & Orbiles St., Ward

(Usual place of abode)

Length of residence in city or town where death ocrurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in whirh employed (or employer)
(c) Name of employer Dont Know

9 BIRTHPLACE (city or town) Dont Know
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant Balto City Police Dept
(Address)

Filed JAN 6 - 1930

Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Struck & knocked down by auto while crossing road

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phila Rd & Orbiles

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Anatomical

(Signed) H J Frame, M. D.

1/3, 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 6 - 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52707 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52707

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Asquith ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Thompson

(a) RESIDENCE NO. 207 Asquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) ? 1860 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Aged Old Record (Address) 207 Asquith St

15 Filed JAN 6 - 1930 C. HUMPSON JONES, Registrar ES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 4, 1930, that I last saw h— alive on Jan 4, 1930 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Forgetfulness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B Brown, M. D.

1/4, 1930 (Address) 380 Courtland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion

DATE OF BURIAL 1/6 1930

20 UNDERTAKER Wm. Leo. H. Holland

ADDRESS 1637 [illegible]

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52708

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2335 E. Fayette St. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry M. Kahlsaen

(a) RESIDENCE NO. 2335 E. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Kahlsaen

6 DATE OF BIRTH (month, day, and year) Dec. 4 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder #7

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Works

(c) Name of employer Lee, Sackett & Son

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Kahlsaen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jennie Kahlsaen

(Address) 2335 E. Fayette St

15 Filed JAN 5 1930 ELLISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2/930

17

I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 3, 1930, that I last saw h alive on Jan 2, 1930 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Uremia (duration) 1 yrs. mos. ds.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Rich, M. D.

1/4, 1930 (Address) 936 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 7, 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52709

CERTIFICATE OF DEATH

22-002 E 52709

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3826 E. Hudson ST., 1-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie McAndrew

(a) RESIDENCE NO. 3826 E Hudson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 3-1882

7 AGE Years 38 | Months 10 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Patrick McAndrew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah Hannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Annie McAndrew

(Address) 3826 E. Hudson St

15 Filed JAN 6 1930 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/30

17 I HEREBY CERTIFY, That I attended deceased from 12/10, 19, to 1/4, 19 30, that I last saw h[illegible] alive on 1/3/30, 19, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophies Cirrhosis

Myocarditis & acute

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema above

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

What was there an autopsy? no

What test confirmed diagnosis?

(Signed) I H Carnell, M. D.

1930 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interbathyd Cem | DATE OF BURIAL 1/8/1 1930

20 UNDERTAKER D. J. A. Moran | ADDRESS 3000 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. All questions are important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 52710

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3518 Virginia Ave, ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leon Hindberg

(a) RESIDENCE NO. 3518 Virginia Ave, ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Molly Hindberg

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Hindberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pupkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 Balto st.

15 Filed JAN 6 - 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1928 to Jan 5, 1930 that I last saw h[illegible] alive on Jan 5, 1930 and that death occurred, on the date stated above, at 5 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

CONTRIBUTORY (Secondary) Mitral stenosis (duration) yrs. mos. 3 ds.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M Hadcock M. D.

19 (Address) 2225 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Woods

DATE OF BURIAL 1-6-1930

20 UNDERTAKER Jack Lewis, 1439 E. Balto St.

ADDRESS

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52711

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52711

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 23-31 Ward)

REGISTERED NO. 75-082

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Parker

(a) RESIDENCE NO. 155 W Hamburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
40				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Martin Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Lena Parker
(Address) 138 W Hamburg St.

Filed JAN 6 1930 H. HANSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Paralysis

6 P (duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J C Elder, M. D.

1, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Jan 7 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1511 W Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52712 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52712

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E Lanvale St. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Zwick

(a) RESIDENCE NO. 1511 E Lanvale St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Zwick

6 DATE OF BIRTH (month, day, and year) April 12 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward Zwick

(Address) 1511 E Lanvale St

15 1930 JOHN JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 24 1929 to Jan 3 1930

that I last saw h alive on Jan 3 1930

and that death occurred, on the date stated above, at 4½ p.m.

The CAUSE OF DEATH* was as follows:

I Pneumonia Lobar, Syphilis

Contributory from Wounded Heart

(duration) 7 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Laboratory

(Signed) Walter Thomas M. D.

1930 (Address) 122 S Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 6 1930

20 UNDERTAKER Chas R. Stevens

ADDRESS 1501 E Fort Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52713

CERTIFICATE OF DEATH

3 | E 52713

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Batto City Hosp. ST., 22-30 WARD)

2—FULL NAME William Gunn

(a) RESIDENCE NO. 904 S. Carey Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) about Sept. 1871 or 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Abt.	58	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement finisher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Bernard Gunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ellen Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm H Reed

(Address)

15 Filed JAN 6 1930, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov 6, 19 29 to Jan 5, 19 30, that I last saw him alive on Jan 5, 19 30 and that death occurred, on the date stated above, at 6 Am m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum Examined

(Signed) Jas Garnett Jr, M. D.

1/5, 19 30 (Address) Batto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 7 1930
20 UNDERTAKER Ralph Hook	ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

(Meri Sabatino)

E 52717

1911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52717

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Light St. 24-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meri Sabatino

(a) RESIDENCE NO. 1739 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Carlo Sabatino

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
84	Not known		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant Mrs Sabatino

(Address) 620 Poplar Grove

15 Filed JAN 6 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 5, 1930.

that I last saw he alive on Jan 3, 1930

and that death occurred, on the date stated above, at 12 30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1/6, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Jan 7 1930

20 UNDERTAKER: New Bath & Cremation — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52715

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52715

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B. 10-W)

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Loner

(a) RESIDENCE NO. 1115 Proctor st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dish washer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Aniseto Loner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Filomen Marsan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Hospital Records

(Address)

15 Filed ....., 19.... C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1929, to Jan. 1, 1930,

that I last saw him alive on Jan. 1, 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thomas Jr. M. D.

1-1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JAN 1930 19

20 UNDERTAKER: Commissioner Health

ADDRESS

important. See instructions on back of certificates.

N6 - 1930

Cor.—10-10-29—A Co.—100 Bks.

E 52716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 52716

1-PLACE OF DEATH

City of Baltimore: (No. 901 Tunbridge Road St., 27-48 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy E. Stockman

(a) RESIDENCE NO. 901 Tunbridge Road St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4/1918

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	11	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Fred Stockman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Eliz. Peterson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Fred Stockman
(Address) 901 Tunbridge Road

15 Filed NOV 6 1930 G. HAMPSON JONES, M. D., Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Brain Tumor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 1 yr

Was there an autopsy? no

What test confirmed diagnosis

(Signed) J. H. Hall M. D.

1/6/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Jan 7 1930

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 52717

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 S. Clinton ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth R. Pabst

(a) RESIDENCE NO. 1701 S. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Pabst

6 DATE OF BIRTH (month, day, and year) July 20-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Ostervogt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Elizabeth Pabst

(Address) 1701 S. Clinton St

15 Filed JAN 6 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21st, 1929, to Jany 3rd, 1930, that I last saw h-er alive on Jany 3rd, 1930 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

CONTRIBUTORY (Secondary) (duration) yrs. 3 mos. 12 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Harold Jones, M. D.

1/6, 1930 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Jan 7 1930

20 UNDERTAKER George W. Fickle

ADDRESS 1737 E. Eager st.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101 E 52718

1—PLACE OF DEATH

REGISTERED NO. 16-26

CITY OF BALTIMORE: (No. 1042 N Fremont ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Cornelius Norris

(a) RESIDENCE NO. 1042 N Fremont ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Elizabeth Norris

6 DATE OF BIRTH (month, day, and year) Sept 15 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman do

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Warehouse

(c) Name of employer State

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER John B. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Elizabeth R ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Aunt Norris

(Address) 1042 N Fremont

15 FILED JAN 6 1930 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/30

17 I HEREBY CERTIFY, That I attended deceased from 12/23/1929, to 1/5/30 19..., that I last saw him alive on 1/5/30, 19..., and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Bronchio-type Pneumonia

(Signed) Edward J. Terry, M. D.

1/5/ 1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 7 1930
20 UNDERTAKER	ADDRESS
W. J. Redmond Sons	Mt Pleasant

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 52719

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1403 N Fulton Ave ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annis Batton Adams

(a) RESIDENCE NO. 1403 N Fulton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo T Thomas Adams

6 DATE OF BIRTH (month, day, and year): March 30 - 1868

7 AGE — Years: 61 — Months: 9 — Days: 4 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Richard C. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bucks Co Pa

12 MAIDEN NAME OF MOTHER: Isabella Yeaton Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bucks Co Pa

14 Informant: Mrs Geo T Adams

(Address) 1403 N Fulton

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 15 1921 to Jan 5 1930, that I last saw h[illegible] alive on Jan 4 1930 and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about (duration) 9 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. H. Duvall, M. D.

1/6. 1930 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 7 1930

20 UNDERTAKER: H. J. Rickards Sons — ADDRESS: North & Pa

1-6-1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52720

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-601 E 52720

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 826 W. Northave ST.; 13-20 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ellen King

(a) RESIDENCE NO. 826 W. North Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. A. King.

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard McElvaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret J. Platner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bremen Germany

14 Informant Mrs. Ella F. Whitet.

(Address) 826 W. North Ave

15 Filed JAN 6 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 4, 1930 that I last saw h[illegible] alive on Jan 4, 1930 and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) J. E. Koerner, M. D.

Jan 6, 1930 (Address) 1301 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Jan 7 1930

20 UNDERTAKER Wm J Pickner & Son ADDRESS North Pa

Spec.—2-29-28—L. F. S.—500 Blks.

E 52721 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52721

CERTIFICATE OF DEATH 100-001

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 2626 Lelunap ST., 10-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Smith

(a) RESIDENCE NO. 2626 Lelunap ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Smith

6 DATE OF BIRTH (month, day, and year) Sept 6th 1868

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
61	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 637

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Lawton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Celia Gilman

(Address) 31 Kelso St.

15 Filed JAN 6 1930 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/3/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 24th 19 29 to Jan 3rd 19 30

that I last saw her alive on Jan 3rd 19 30

and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

duration Sudden

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. S. Silverhart, M. D.

1/5 1930 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Jan 7th 19 30

20 UNDERTAKER C. H. Dupont — ADDRESS 850 N. Bethel St.

Spec.—1-12-23—M&T—500 Bks.

E 52722

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52722

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1602 Harlem Ave ST. (WARD) 46-22

2-FULL NAME Mary Bell

(a) RESIDENCE No. 1602 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bessie Hall

(Address) 1602 Harlem Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

By AKS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1929 to Jan. 4, 1930.

that I last saw her alive on Jan 4, 1930,

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

6 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

4 weeks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. S. Taylor M. D.

1/6, 1930 (Address) 522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 1/7/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1603 Druid Hill

JAN 6 - 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52723

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52723

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. Wolfe St. ST., 2-H WARD)

2—FULL NAME Elizabeth M. Backs.

(a) RESIDENCE NO. 12 S. Wolfe St ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam J. Backs.

6 DATE OF BIRTH (month, day, and year) Aug 20th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70 / 71		4	13 / 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Adam J. Schmitt

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Adam J. Backs. (Address) 12 S Wolfe St.

15 Filed 19 C. HAMILTON JONES, M. Registrar

JAN 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Jan 3, 1930 that I last saw her alive on Jan 2, 1930 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiovascular disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Keller, M. D.

1-5, 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan. 7 1930
20 UNDERTAKER C. Lilly + Zeiler inc	ADDRESS 403 S. Wolfe St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52724

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 24 Ward)

2-FULL NAME Mullis Shafer

(a) RESIDENCE NO. 1925 E Lombard St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Denmark
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Jos. Feldman (Friend)
(Address) 106 S. Exeter St.

15 Filed ....., 19.... C. HARRISON JONES, M. D.
Per ..... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of —

Was there an autopsy? —

What tests confirmed diagnosis? —

(Signed) John C. Wades, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 7 1930

20 UNDERTAKER Lilly & Zeilenga — ADDRESS 403 E. Monument

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NG

Spec.—2-29-28—L. F. S.—500 Blks.

E 52725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52725

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospl REGISTERED NO. 168

CITY OF BALTIMORE: (No. Balto Md. ST., 221 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Matas (MATTES)

(a) RESIDENCE NO. 701 S. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Matas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Loehrkolb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Reeves

(Address) Balto City Hospl

15 Filed JAN 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—4—30

17 I HEREBY CERTIFY, That I attended deceased from 1—3—, 1930, to 1—4—, 1930, that I last saw h.er alive on 1—3—, 1930 and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

(Coroner)

Suicide by Lysol

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pachomeningitis Hysterica = Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry J. Grimm, M. D.

, 19 (Address) Balto City Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Jan 9th 1930
UNDERTAKER Lilly & Gibson Co.	ADDRESS 403 S. Wolfe St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52726 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52726

CERTIFICATE OF DEATH. 34-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., WARD 37 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lockbockler Bonkelm

(a) RESIDENCE NO. 806 S. Conkling ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary M. Lockbockler

6 DATE OF BIRTH (month, day and year) April 6 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. Practice

(c) Name of employer —

9 BIRTHPLACE (city or town) St. Louis Mo, (State or country)

PARENTS

10 NAME OF FATHER Francis X. Lockbockler

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Teresa Eichorn

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Eugenia M. Lockbockler (Address) 806 S. Conkling St

15 Filed JAN 6 1930, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 6 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-24, 1929, to 1-6, 1930, that I last saw him alive on 1-3, 1930, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (left internal capsule)

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) J. B. Hundley, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Jan 9 1930

20 UNDERTAKER Libby & Zeiler Inc. — ADDRESS 40 S. Howard St

N6 - 1930

IMPORTANT—Should be carefully supplied. Name should be entered in full. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52727

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 52727

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 28-66

CITY OF BALTIMORE: (No. 4V-0V Prospect Circle) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nannie B. Thomas

(a) RESIDENCE NO. 4V-0V Prospect Circle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. — mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William Thomas

6 DATE OF BIRTH (month, day, and year) June 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	92	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Pa

PARENTS

10 NAME OF FATHER William Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William R Elliott

(Address) 4V-0V Woodside Ln Hills

15 Filed JAN 6 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1929, to Jan 6, 1930, that I last saw h[illegible] alive on Jan 5th, 1930 and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis
Myocardial insufficiency.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. Michel, M. D.

Jan 6 1930 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frostburg Md	Jan 7 1930
20 UNDERTAKER	ADDRESS
Chas. S. Black	742 W. North Ave

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52728 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6X 128 E 52728

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) St Agnes Hospital ST. 2572 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Clements.

(a) RESIDENCE NO. 107 Bloomsbury Ave ST. Catonsville Md
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29, 1926

7 AGE — Years: 3 yrs. Months: 7 Days: 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Philip Clements.

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Esther Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Philip Clements.
(Address) 107 Bloomsbury Ave. Catonsville Md

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar
Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-1 1930, to 1-5 1930, that I last saw ~~him~~ alive on 1-5 1930, and that death occurred, on the date stated above, at 6.40 P.M.

The CAUSE OF DEATH* was as follows:

Entero-colitis ~~typh~~ (of unknown etiology)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Paul Cohen, M. D.

(Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL: Jan. 8 1930

20 UNDERTAKER: Harry N. Ritzke ADDRESS: 411 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N6

Spec.—8-16-29—L. F. S.—100 Blks.

E 52729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 135 E 52729

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4-30 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Gardner

(a) RESIDENCE NO. Ellicott City, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Mary D. Gardner

6 DATE OF BIRTH (month, day, and year) Feb. 14 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas J. Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Christina Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William Gardner

(Address) Ellicott City

15 Filed C. HAMPSON JONES, M. D. Registrar

1-6-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 6 - 1930

17 I HEREBY CERTIFY, That I attended deceased from December 1 - 1929, to January 6 - 1930, that I last saw h alive on January 6 - 1930 and that death occurred, on the date stated above, at 6:35 A m.

The CAUSE OF DEATH* was as follows:

Uraemia (Post operative following prostatectomy)

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12 - 30 - 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical signs + symptoms.

(Signed) C. W. Peake M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Cem. Ellicott City	Jan. 9 1930

20 UNDERTAKER Mary P. Starr ADDRESS Ellicott City Md.

IMPORTANT. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52730

1—PLACE OF DEATH

REGISTERED NO. 27-48

CITY OF BALTIMORE: (No. 5310 York Road ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME L. Netta Farley

(a) RESIDENCE NO. 5310 York Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9th 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Harriett Tunney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Chas F. Farley

(Address) 504 E. 41st

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to Jan 5, 1930, that I last saw h.. alive on Jan 5, 1930 and that death occurred, on the date stated above, at 9-30-A. m.

The CAUSE OF DEATH* was as follows:

Influenza Edema of Lungs
Pulmonary Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) See above

See above (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Ormiss, M. D.

1.6., 1930 (Address) 634 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 8th 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

important. See instructions on back of certificates.

Spec.—3-29-28—L. F. S.—500 Blks.

E 52731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 52731

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Kelly

(a) RESIDENCE NO. 5401 Morella Raod ST., Hamilton WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William J. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen E. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JAN - 1930 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1930, to Jan. 6, 1930, that I last saw him alive on Jan. 6, 1930 and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. Hamilton Jones, M. D.

1-6, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cemetery (Long Green Md.) DATE OF BURIAL 1/9/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52732

CERTIFICATE OF DEATH.

90

E 52732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2840 Georgetown Rd ST. 25-12 WARD)

2-FULL NAME. Nicholas Ross,

(a) RESIDENCE NO 2840 Georgetown Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs mos ds. How long in U. S., if of foreign birth? 19 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Ross

6 DATE OF BIRTH (month, day and year): Apr 15, 1862

7 AGE: Years 67 Months 8 Days 21 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Australia

PARENTS

10 NAME OF FATHER: Joseph Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Australia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Australia

14 Informant (Address): Catherine Ross 2840 Georgetown Rd

15 Filed JAN 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1929 to January 6, 1930, that I last saw h[illegible] alive on January 5, 1930, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

about (duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A. Stevens, M. D.

1/6, 1930 (Address) 1901 Griffis Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL: 1/9 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52733

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore 1600 S. A.S-26 Ward)

2-FULL NAME Laura Brown-Ryan

(a) RESIDENCE NO. 920 Nine 4X St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

1936 1 E 52733

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869 1869

7 AGE: Years 61; Months; Days; or LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

070

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Daniel Easton
(Address) 916 Penna ave

15 Filed JAN 7 - 1936 HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1936

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Acc Burns Legs (Ans)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? —

Did operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Ex

(Signed) G. E. Wade M. D.

(Address) 4316 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 1-7-36

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Penna

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52734

CERTIFICATE OF DEATH

× 199 L

REGISTERED No. E 52734

1-PLACE OF DEATH

City of Baltimore: (No. 1602 Fremont St., 17-19 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wolfe Glasner

(a) RESIDENCE NO. 112 Newton Av St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Glasner

6 DATE OF BIRTH (month, day, and year) unk

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 88
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Philip Glasner

11 BIRTHPLACE OF FATHER (city or town) Russ
(State or country)

12 MAIDEN NAME OF MOTHER Hannah — ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russ.

14 Informant
(Address) Jos. L. Lewis 1439 E. Baltimore St.

Filed [illegible] 19 H. C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-4-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cirrhosis Pancreas

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pyel. Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted — If not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wesley M. Carroll, M. D.
Jan 6, 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom — DATE OF BURIAL 1/7 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

Jan 10 1930 100

E must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

9325 E 52735 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

+129 E 52735

REGISTERED NO.

1—PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST., 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Souder

(a) RESIDENCE NO. 1 & N. Coal St — ST., WARD Shamokin-Pa —
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mabel

6 DATE OF BIRTH (month, day, and year) June 10, 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43 —	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Pa —

PARENTS

10 NAME OF FATHER Richard Souder

11 BIRTHPLACE OF FATHER (city or town) Pa — (State or country) England

12 MAIDEN NAME OF MOTHER Eliz. Brannan

13 BIRTHPLACE OF MOTHER (city or town) Pa — (State or country)

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. HARRISON JONES, M. D. Registrar

N7 - 1930 KM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Jan 6, 1930, that I last saw him alive on Jan 6, 1930 and that death occurred, on the date stated above, at 2 26 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

6-8 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

? (duration) yrs. ? 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Chemistry

(Signed) Hedwig Kaeser, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shamokin, Pa.	Jan. 7, 1930

20 UNDERTAKER John O. Mitchell & Sons M. B. Mitchell

ADDRESS 1900 Eutaw Pl.

IF DEATH IS FROM VIOLENCE, so that it may be properly classified, state whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Fill in all items, as they are important. See instructions on back of certificates.

Spec.—i-10-21—M&T—1500 Bks.

Annie A Tanner.

E 52736 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 McCulloh ST. 11-24 WARD)

REGISTERED NO. 1005-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Tanner

(a) RESIDENCE NO. 1033 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Holt J. Tanner

6 DATE OF BIRTH (month, day, and year): 1876-

7 AGE: Years 63 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer): House work

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Balto. City

PARENTS

10 NAME OF FATHER: — Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City

12 MAIDEN NAME OF MOTHER: Rachel Mosher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. City

14 Informant: Holt J. Tanner (Address) 1033 McCulloh

15 Filed JAN 7 1930 H. L. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/4 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/1 1930, to 1/4 1930.

that I last saw h[illegible]ive on 1/4/1930

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arthritis due to

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no,

What test confirmed diagnosis? Physical

(Signed) H. Lee Elsin M. D.

1930 (Address) 524 North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 1/7 1930

20 UNDERTAKER: Samuel Kennedy & W. Biddle — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52737

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hosp (St.) 1-9-30 (Ward)

2-FULL NAME Wm Oliver

(a) RESIDENCE NO. 111 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Oliver

6 DATE OF BIRTH (month, day, and year) Dont Know 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Maggie Oliver
(Address) 111 E Mount St

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptured aman intestum struck & knocked down by hit & Run driver Hom

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneu

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lexington & Gilmor

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Surgical

(Signed) H Braun, M. D.

1/7, 1930 (Address) 2939 Wm Elderly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harwood town Md

DATE OF BURIAL 1/8 1930

20 UNDERTAKER Leon Hall

ADDRESS 753 Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52738

CERTIFICATE OF DEATH

100-001

E 52738

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2500 Eager Road ST., 7-12 WARD)

2—FULL NAME Emma Klarek

(a) RESIDENCE NO. 2500 Eager Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? 1/2 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

OCCUPATION OF DECEASED

Trade, profession or particular kind of work Housework

General nature of industry, business, or establishment in which employed (or employer) Home

Name of employer

BIRTHPLACE (city or town) or country) Austria

NAME OF FATHER Carl Klarek

BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mary Klarek

(Address) 2500 Eagle Road

15 Filed JAN 7 - 1930 AM PM JONES, M. D. Registrar

Important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 30

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 5, 1930, that I last saw h[illegible] alive on Jan 5, 1930 and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Xray

(Signed) Jacob Pokorny, M. D.

, 19 (Address) 2202 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 8 1930

20 UNDERTAKER Gust Boucot Son ADDRESS 1906 E Monument

Spec.—8-16-29—L. F. S.—100 Bks.

E 52739

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 52739

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3419 Keswick Road. ST., 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William D. Myers.

(a) RESIDENCE NO. 3419 Keswick Road. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (late) Mary Myers.

6 DATE OF BIRTH (month, day, and year) Jan 14, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John H. Haynes
(Address) 3419 Keswick Road.

15 Filed Jan 7, 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Jan 6, 1930, that I last saw h in alive on Jan 5 1930 and that death occurred, on the date stated above, at 6:24 m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Aortitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davies, M. D.

1-6. 1930 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden.	Jan 8, 1930

20 UNDERTAKER Rhinowethlon

ADDRESS 3614 Chestnut Ave.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52740

CERTIFICATE OF DEATH

160 E 52740

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 N. Durham ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Wilkins Jr.

(a) RESIDENCE NO. 945 N Durham St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., if foreign birth? yrs. 3 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	✓	3	12	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER George Wilkins Sr

11 BIRTHPLACE OF FATHER (city or town) Fredo (State or country) Va.

12 MAIDEN NAME OF MOTHER Josephine Miller

13 BIRTHPLACE OF MOTHER (city or town) Church Rd (State or country) Va

14

Informant Josephine Wilkins

(Address) 945 N. Durham St

Filed JAN 7 1930 CHARLES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Jan 7, 1930, that I last saw h[illegible] alive on Jan 7, 1930 and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(duration) yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Calvin B. LeCompte, M. D.

1/7, 1930 (Address) 1113 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cemetery	1/7/30
20 UNDERTAKER	ADDRESS
Robert Williams	1515 McElderry St

important. See instructions on back of certificates.

Cor.—10-19-29—A Co.—100 Bks.

E 52741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 E 52741

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 227 Grindall St. St. 24-33 Ward)

2-FULL NAME Alonza Lamphere Sr.

(a) RESIDENCE NO. 227 Grindall St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If ~~married~~ widowed, or ~~divorced~~ HUSBAND of ~~WIFE~~ of Clara Lamphere.

6 DATE OF BIRTH (month, day, and year) March 4, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	61 67	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 40
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New Jersey.
(State or country)

PARENTS

10 NAME OF FATHER Charles Lamphere.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Alonza Lamphere Jr.
(Address) 227 Grindall St.

15 Filed ..., 19... [illegible] Registrar

JAN 7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [signature], M. D.

1/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL 1/7 1930

20 UNDERTAKER L. F. McCully

ADDRESS 1306 Fort

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-19-30—L. F. S.—500 Blks.

E 52742 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. E 52742

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6012 Wallis Ave ST. 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Lincoln Herford

(a) RESIDENCE NO. 6012 Wallis Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive F. Herford

6 DATE OF BIRTH (month, day, and year) Jany. 26, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Julius Herford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Rosette Breslau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mr. E. Rosenstein

(Address) Liberty Heights Ave.

15 Filed JAN 7 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 5, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to Jan 5 1930, that I last saw h alive on Jan 5 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - chronic nephritis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? Examined no

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Leutz, M. D.

1-6, 1930 (Address) Temple Gardens Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem.

DATE OF BURIAL 1/7 1930

20 UNDERTAKER Harid. Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52743 90 E 52743

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 25-77

CITY OF BALTIMORE: (No. 527 Nottingham Road ST. Ten Hills WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Ramsey Hughes

(a) RESIDENCE NO. 527 Nottingham Rd, Ten Hills ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John . Hughes, Jr.

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph E. Ramsey

11 BIRTHPLACE OF FATHER (city or town) Cecil County (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Abigail Clarke

13 BIRTHPLACE OF MOTHER (city or town) Cecil County (State or country) Maryland

14 Informant Mr. Milton Roberts

(Address) 527 Nottingham Road, Ten Hills

15 Filed JAN 9 1930 C. H. Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 7, 1929, to Jan 7, 1930, that I last saw her alive on Jan 6, 1930 and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Mercer Ford, M. D.

19 (Address) 20 S. Paca St

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan. 9 1930
20 UNDERTAKER Joseph D Cook	ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52744

CERTIFICATE OF DEATH

124 E 52744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 18-N Ward)

2-FULL NAME Daisy Thomas

(a) RESIDENCE NO. 226 Rock St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ~~ds.~~ How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	colored	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Gus Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Gray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Emma Thomas
(Address) 315 Schroeder St

15 Filed ... 19... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
AC Inf Gall Bladder

(duration) ... yrs. ... mos. 2 ds.
CONTRIBUTORY C. Lawton
(Secondary)
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Med Exs.

(Signed) G. C. Glades, M. D.
1/7, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Jan 7, 1930

20 UNDERTAKER Mrs Katie R. Williams — ADDRESS 322 Schroeder St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52745

CERTIFICATE OF DEATH

1-001 V

E 52745

1-PLACE OF DEATH

City of Baltimore: (No. 1419 Cairo St., 19-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celia M Thomas

(a) RESIDENCE NO. 1419 Cairo St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fma	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nov 5 1929

6 DATE OF BIRTH (month, day, and year) Nov 2-1929

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Thomas

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martin Chase

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Martha Thomas
(Address) 1419 Cairo

Filed JAN 7 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Diagnosis

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 1-7-30

20 UNDERTAKER Samuel Carlon

ADDRESS 716 Park Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-002 L

CERTIFICATE OF DEATH

E 52746
1—PLACE OF DEATH

E 52746
REGISTERED NO.

CITY OF BALTIMORE: (No. Lyndenhurst Hospital 4-46 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Theresa Harrison

(a) RESIDENCE NO. 627 E. 29th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 11 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 28, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	4	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child —

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William F. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bertha Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant William F. Harrison
(Address) 627 E 29th St.

15 Filed JAN 7 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 5, 1930, that I last saw her alive on Jan 5, 1930 and that death occurred, on the date stated above, at 5 15 p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Tonsillar & Nasal Diphtheria)

(duration) 0 yrs. 0 mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? 627 E. 29th St

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Isley, M.D.

(Address) Lyndenhurst Hospital 1-6, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 1/7, 1930

20 UNDERTAKER George A. Farley Funeral Service

ADDRESS

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

E 52747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 V

E 52747

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4012 Edmondson St. 16-66 Ward)

2-FULL NAME Mary E Robinette

(a) RESIDENCE No. 4012 Edmondson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo.

6 DATE OF BIRTH (month, day, and year) Aug 27 1862

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
67	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ohio,
(State or country)

PARENTS

10 NAME OF FATHER John Hanafee.

11 BIRTHPLACE OF FATHER (city or town) Ohio
(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 Informant Mary E. Biden
(Address) 4012 Edmondson.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Coroner, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy (duration) ..... yrs. Sudden mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Evelyn Holbrook M. D.
Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 1/7 1930

20 UNDERTAKER Joyce & Talley Fulton

ADDRESS Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 7 1930

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52748

CERTIFICATE OF DEATH

1—PLACE OF DEATH No. 52748

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1215 Ensor ST.) (10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine M. McAvoy.

(a) RESIDENCE NO. 1215 Ensor ST.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced (or) WIFE of Owen J. McAvoy

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
Abt.	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Edward Fitz Patrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Edward McAvoy

(Address) 1215 Ensor St.

15 Filed 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1930

17 I HEREBY CERTIFY That I attended deceased from March 1 29 to Jan 6 1930, that I last saw h[er] alive on Dec 31 or 1929, and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Intest. Lesion Pneumonia

CONTRIBUTORY (Secondary) Senility - Artero sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical signs

(Signed) L. McCarthy, M. D.

1/6/ 1930 (Address) 1114 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Jan. 9 1930

20 UNDERTAKER Henry Hoeck Sons

ADDRESS 1301 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

E 52749

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 E 52749

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 7-10 Ward)

2-FULL NAME Frank A Boehm

(a) RESIDENCE NO. 508 N Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. \ mos. \ ds. How long in U. S., If of foreign birth 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Boehm

6 DATE OF BIRTH (month, day, and year) Not Kn

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Antone Boehm

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Kn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Kn

14 Informant Mrs Clara Boehm
(Address) 508 N. Glover

15 Filed JAN 7 - 1930 C. HERBERT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

Jan 5 1930

(Signed) H C Grades, M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 9 1930
20 UNDERTAKER Henry Hoeck Sons Inc,	ADDRESS 1301 E Eager

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3539 Park Heights Ave ST.) (WARD) 5-56

2—FULL NAME Matilda Levy

(a) RESIDENCE NO. 3539 Park Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Levy

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Morris Tipper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rachel Goldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Morris Levy

(Address) 3539 Park Heights Ave

15 Filed JAN 7 - 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7/30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1929, to Jan 7 1930, that I last saw her alive on Nov. 27 1929 and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Coronary Disease, arteriosclerosis
Cardiac Hypertrophy + degeneration
aortic Stenosis

anal (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. Y

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam + Laboratory

(Signed) G. F. Rau, M. D.

Jan. 7, 1930 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N. Y.	Jan 8, 1930
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Balto St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52751

100-001 E 52751

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

2—FULL NAME Rosetta Hazel

(a) RESIDENCE NO. 15-15-E-Monument St WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7 8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child - at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Hazel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ida Hazel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 7 1930 C. HAMPSON JONES, M.D. Registrar
Per ARS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3-30

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 3, 1930
that I last saw h.. alive on Jan 3, 1930
and that death occurred, on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Benjamin E. Hodgson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 7 - 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52752

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52752

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 1-3

CITY OF BALTIMORE: (No. 318 S. Patterson Pk. Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wanda Zdanowicz

(a) RESIDENCE NO. 318 S. Patterson Pk. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ~~15~~ mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Zdanowicz

6 DATE OF BIRTH (month, day, and year) June 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓ 43	42	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER L. Kazmierowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant J. Zdanowicz

(Address) 318 S. Patterson Pk. Ave

15 Filed 7-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct., 1928, to Jan 5, 1930, that I last saw her alive on Jan 4, 1930 and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation 1 day

Myocardial degeneration, Cardiac Hypertrophy

Chronic Passive congestion of Liver

Mitral Regurgitation (duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam & Laboratory

(Signed) A. F. Rios, M. D.

Jan 7, 1930 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 9 1930

20 UNDERTAKER J. W. Ozarowski 1930 ADDRESS Eastern Ave

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52753

CERTIFICATE OF DEATH.

123 E 52753

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (NO.) Caton & Wilkens Ave ST. 3-4 (WARD)

2-FULL NAME Mrs Fronie Ulrich

(a) RESIDENCE NO. 4195 S. Dallas ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: George

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE — Years: 59 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Ulrich
(Address): 4195 S Dallas St.

15 DEC 7 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-4-30 19

17 I HEREBY CERTIFY, That I attended deceased from 11-30 .1929. to 1-4 .1930.

that I last saw her alive on 1-4 .1930,

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

indefinite
(duration) yrs mos ..... ds.

CONTRIBUTORY (Secondary) Cholangitis

(duration) yrs. 1 mos. 30 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? 2 Date of 12-4-29 1-4-30

Was there an autopsy? No. Removal of Gall Stone

What test confirmed diagnosis? Operation

(Signed) Paul Cohen M. D.

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Jan — DATE OF BURIAL: 8 1930

20 UNDERTAKER: F W Brazewski 19 — ADDRESS: 30 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 52754

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52754

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 4116 Edmondson Ave St., 16-65 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Geipe

(a) Residence No. 4116 Edmondson Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, wh

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Eliz Geipe

6-DATE OF BIRTH (month, day and year) June 24, 1858

7-AGE. 71 yrs. 6 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer) 085

(c) Name of employer self

9-BIRTHPLACE (city or town) (State or Country), Penn.

PARENTS.

10-NAME OF FATHER Benjamine Geipe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Rachael Schaffer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn

14- (Informant) Gertrude Geipe Lydon

(Address) 4116 Edmondson Ave

15- Filed ... 193 ... Registrar.

JAN 7 - 1930

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 6-30

17- I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1929 to Jan 6, 1930 that I last saw him alive on Jan 6, 1930 and that death occurred, on the date stated above, at 2:50 m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(Duration) yrs. mos. 3 ds

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 6 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual signs

(Signed) Geo. E. Wells M. D.

19 (Address) 410 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Louden Park Cem.	1/8/30 19....
20-UNDERTAKER.	ADDRESS
E. Lemmon Lemmon	4513 Park Heights Ave.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52755

CERTIFICATE OF DEATH

90

E 52755

1-PLACE OF DEATH 1400 W. Lexington St.

City of BALTIMORE: (No.) Aged Men Home St. 19-27 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Rehbein

(a) RESIDENCE NO. Aged Men Home St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 30 - 1853

7 AGE: Years 76 Months 8 Days 7

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Gardner

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER: Sergo Rehbein

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Catherine Ort

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant: Mr. John McMahon

(Address) Green Spring Ave

15 [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to Jan. 6, 1930 that I last saw him alive on Dec. 23, 1929 and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Edwin O Jarrett M. D.

19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Hope Cemetery Date of Burial 1-8-30

UNDERTAKER: A. S. Aldershall ADDRESS 5539 Falls Rd

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 - 1930

Spec.—1-12-23—M&T—500 Bks.

E 52756 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52756

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. James O. Holden

(a) RESIDENCE NO. 913 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Catholic Priest

(b) General nature of industry, business, or establishment in which employed (or employer) R.C.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Sealion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record (Address)

15 Filed ..... 19 .....

[illegible] M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1928, to Jan. 5, 1930,

that I last saw him alive on Jan 4, 1930

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

chronic nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 1/8 1930

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

7-1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 52757

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52757

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 91-082

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Keplinger

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Keplinger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sophie Cairns

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston + Valley

15 Filed 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan: 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1929, to Jan 7 1930, that I last saw h... alive on Jan 6 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D V Timanus M. D.

1/7. 1930 (Address) 1216 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presb Cem.	Jan 9 1930
20 UNDERTAKER	ADDRESS
C. Jolly Bares Sons	Towson

important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 52758 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52758

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1218 W. Pratt St. St. 18-29 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lilly Bloecher

(a) Residence No. 1218 W. Pratt St. St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Bloecher

6-DATE OF BIRTH (month, day and year) 1861. (do not write what day)

7-AGE. 69 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer self

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Geo Worley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Spencer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Carrie Carter

(Address) 1218 W. Pratt St.

15- FILED JAN 7 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 5, 1930

17- I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929 to Jan. 5 1930

that I last saw her alive on Jan 5, 1930

and that death occurred, on the date stated above, at 10 a.m. p.m.

The CAUSE OF DEATH* was as follows:

cardiac insufficency due to myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac dilatation

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George A. Kemp, M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon park — DATE OF BURIAL, Jan. 8 1930

20-UNDERTAKER, W. M. Cook — ADDRESS 1217 St Paul St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7

Spec.—1-10-21—M&T—1500 Bks.

E 52759

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52759

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hosp. of Baltimore

CITY OF BALTIMORE: (No. ..... ST.) 1-13 WARD)

2-FULL NAME Helen A. Mauck

(a) RESIDENCE NO. 1936 Maxwell ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2-3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) February 2, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	14 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balt, Md.

PARENTS

10 NAME OF FATHER Louis Mauck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago, Ill

12 MAIDEN NAME OF MOTHER Alvina Yelkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Mauck
(Address) 1936 Maxwell Ave

15 Filed ..... 19 .....

N 7 - 1930

C. RAMPSON JONES, M. D.
Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-29 1929 to 1-6 1930.

that I last saw h alive on 1-6 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (right)
Empyema (rt.)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) -

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Post mortem

(Signed) H. H. Silver, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. | DATE OF BURIAL: Jan. 9 1930

20 UNDERTAKER: Stephen J. Fiolkowski | ADDRESS: 1100 N. Kenwood ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52760

CERTIFICATE OF DEATH

99 E 52760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1644 S. Charles St. St. 23-32 Ward)

2-FULL NAME Catherine Wise.

(a) RESIDENCE NO. 1644 S. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If ~~married~~ widowed, ~~or divorced~~ (or) WIFE of William G. Wise.

6 DATE OF BIRTH (month, day, and year) July 23, 1846

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	83	5	14 13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Riemerschneider.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Caroline Pannington. (daughter)
(Address) 1644 S. Charles St.

15 Filed ..... 19 C. HAMPSON JONES, M. D., Registrar

JAN 7 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.
Pulmonary Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto L. Reinhardt, M. D.

1/7 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL Jan 8 1930

20 UNDERTAKER E. Schloman Son

ADDRESS 1039 Hanover

If death occurred in a hospital or institution, give its NAME instead of street and number. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52761

CERTIFICATE OF DEATH

197 ✓ E 52761

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 127 Pearl St., 4-25 Ward)

2-FULL NAME Louis Lorosco

(a) RESIDENCE NO. 127 Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~unknown~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Restaurant Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Sam Presto
(Address) 1616 W. Fayette St

15 Filed 19 G. HAMPSON JONES, M. D. Registrar

JAN 7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan. 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to gunshot wounds of abdomen & brain.
Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

1/7 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	1/8 1930
20 UNDERTAKER W. H. Coop	ADDRESS 1317 Eutaw

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52762

REGISTERED NO. 27-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannibal Hiss

(a) RESIDENCE NO. 3114 Ruckert Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Daisy Hiss

6 DATE OF BIRTH (month, day, and year) 2-4-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Valiant & Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo Hiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Catherine Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Daisy A Hiss

(Address) 3114 Ruckert Ave

15 Filed 1-7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1930

17 I HEREBY CERTIFY. That I attended deceased from 12-4-29 19 to 1-7 19 30, that I last saw h[illegible] alive on 1-7 19 30 and that death occurred, on the date stated above, at 5 22 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 1/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr Davis
33- Chestnut
E 52763
74001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2126 Woodberry St. Ave WARD) 13 - 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Stanton

(a) RESIDENCE NO. 2126 Woodberry ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Stanton

6 DATE OF BIRTH (month, day, and year): March 4-1854

7 AGE: Years 75 | Months 10 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: ? McKnew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Racine Freeman

(Address) 2126 Woodberry Ave

15 Filed JAN 7 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-6-1930

17

I HEREBY CERTIFY. That I attended deceased from Jan 3 1930 to Jan 6, 1930, that I last saw h 2s alive on Jan 6, 1930 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davis, M. D.

1-7 1930 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery

DATE OF BURIAL: 1/8 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52764

CERTIFICATE OF DEATH

90 E 52764

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1205 Mosher (St.) 1-6-23 (Ward)

2-FULL NAME Ida Clemons

(a) RESIDENCE NO. 1205 mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm Clemons

6 DATE OF BIRTH (month, day, and year) Sept 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Mrs. Stewart

9 BIRTHPLACE (city or town) (State or country) Calvert County md

PARENTS

10 NAME OF FATHER Richard Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sidney Grimes

(Address) 1205 Mosher St Balto md

15 Filed 1930 H. Hampson Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 5th 1930 to Jany 5th 1930, that I last saw her alive on Jany 5th 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Probably (duration) 7 D yrs. — mos — ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis, Heart Asthenia with probable rupture (duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. B. Hascock, M. D.

, 19 (Address) 1802 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co md

DATE OF BURIAL Jan 8 1930

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1303 Presstman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N 7

Spec.—8-16-29—L. F. S.—100 Blks.

E 52765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52765

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 N Carrollton Av (St.) 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsie Williams

(a) RESIDENCE NO. 1017 N Carrollton Av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Williams

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va

PARENTS

10 NAME OF FATHER Jim Brooktmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Clarance M. Williams

(Address) 1017 N. Carrollton ave

15 Filed ..., 19... CLARENCE JONES, M. D. Registrar

1-7-1930 Acc

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6. 30

17 I HEREBY CERTIFY That I attended deceased from Dec 23 1929 to Jan 6 1930

that I last saw h.er alive on Jan 6 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) J. H. Woolridge, M. D.

1-7-1930 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northumberland Co Va	Jan 8 1930
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Pennsylvania Ave

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 52766

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 52766

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 331 S. Ann St. St 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Wolski

(a) RESIDENCE NO. 206 S. Wasington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
64	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work $10

(b) General nature of indusiry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Frank Wolski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frank Wolski

(Address) 209 S. Castel St.

15 Filed [illegible] 1930

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

1/3 Signed C. C. Wades (Coroner) M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Stanislaus Cem. Jan 8 1930

20 UNDERTAKER ADDRESS

John M Weber 512 Chester

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

7 - 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52767
1-PLACE OF DEATH

90 ✓

REGISTERED NO. E 52767

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 902 Russell St. St., Ward)

2-FULL NAME William A. Wright.(C)

(a) RESIDENCE NO. 902 Russell St. St., 21-31 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Florence Wright.(C)

6 DATE OF BIRTH (month, day, and year) June 6, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	6	30 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer

9 BIRTHPLACE (city or town) A. A. Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Wright.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Annie Turner.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) A. A. Co. Md.

14 Informant Florence Wright.(C) wife.
(Address) 902 Russell St.

15 Filed JAN 8 1930 C. HAMPSON JONES, M. D. Registrar
For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas Eberhardt M. D.

1/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. — DATE OF BURIAL 1-8 1930

20 UNDERTAKER John H. Toadvine — ADDRESS 4027 Round Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52768

CERTIFICATE OF DEATH

31 E 52768

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1413 Division ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernice Wanda Duffin

(a) RESIDENCE NO. 814 Presidential ST., 16-27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 28 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto MD

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Duffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Henry Duffin

(Address) 924 Hanover St

15 Filed 1930 C. HAY. SCOTT JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Jan 7, 1930, that I last saw h[illegible] alive on Jan 7, 1930 and that death occurred, on the date stated above, at 1 30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

* (Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 8 1930

20 UNDERTAKER Thomas E Wright — ADDRESS 864 Mary

important. See instructions on back of certificates.

JAN 8 - 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52769

CERTIFICATE OF DEATH

101-001

E 52769

1—PLACE OF DEATH Cambridge Arms Apts. REGISTERED NO.

CITY OF BALTIMORE, ON Charles & 34th ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Teresa P. Coulbourn

(a) RESIDENCE NO. Charles & 34th ST., 12-49 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 0 mos. 13 ds. How long in U. S., if foreign birth? yrs. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of: Robert M. Coulbourn

6 DATE OF BIRTH (month, day, and year): Dec. 24 1850

7 AGE — Years: 79 | Months: 0 | Days: 13 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Dominico Palagano

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Amelia Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Robert M. Coulbourn

(Address) Charles & 34th Sts.

15 Filed JAN 8 - 1930

16 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6th 1930

17 I HEREBY CERTIFY That I attended deceased from Jan 4th, 1930, to Jan 6th, 1930, that I last saw her alive on Jan 6th, 1930 and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Jan 8 1930

20 UNDERTAKER: C. M. Fuchs ADDRESS: Lauer Bond Rock & Pa

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52770

CERTIFICATE OF DEATH

99-003 E 52770

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 305 Forrest St., Ward)

2-FULL NAME Mary A. Richardson 5-8

(a) RESIDENCE NO. 305 Forrest St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f.

4 Color or Race: wh.

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 27/29.

7 AGE: Years 2 | Months 5 mos | Days 3 days | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General naturo of industry, business, or establishment in which employed (or employer) wh
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm Douglas

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lillie Richardson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Lillie Richardson
(Address) 305 Forrest

15 Filed 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. T. Riley M.D. Town M. D.

(Address) Jan 6 30 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: Jan 9 1930

20 UNDERTAKER: Edward Bryan — ADDRESS: 637 orleans st

Hon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-12-25—L. F. S.—100 Blks.

E 52771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52771

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Gold Spring ave. ST., WARD) 27-56

2—FULL NAME Clinton J. (J. C.) Cullum

(a) RESIDENCE NO. 3107 Gold Spring Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa M. Cullum

6 DATE OF BIRTH (month, day, and year) May 28-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardwood Floor Layer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Moses Cullum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Sarah E. Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Louisa M. Cullum

(Address) 3107 Gold Spring Ave

15 Filed JAN 10 1930 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 19 30 to Jan 7 19 30, that I last saw h[illegible] alive on Jan 6 19 30, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis

Arteriosclerosis

about 2-3 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

and Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1403 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan 9 1930
20 UNDERTAKER George W. Zihler	ADDRESS 1737 E. Eager St.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52772

SHERR

✓ E 52772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. (ST.) 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Sherr

(a) RESIDENCE NO. 1600 Appleton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Sherr

6 DATE OF BIRTH (month, day, and year): March

7 AGE — Years: 63 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1439 E. Baltimore St

JAN 8 1930 File

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/8 1930

17 I HEREBY CERTIFY, That I attended deceased from 12/23, 1929, to 1/8, 1930.

that I last saw her alive on 1/8, 1930

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of large bowel.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) A. A. Silver M. D.

1/8, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrersburg Penna

DATE OF BURIAL: 1/8 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52773

CERTIFICATE OF DEATH

100-001

E 52773

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 700 W. Fairmount Ave Ward)

2-FULL NAME Moselle A. Barnes 4-26

(a) RESIDENCE NO. 700 W. Fairmount Ave 4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Negro	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 13-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Fred Barnes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Lula Manuel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Fred Barnes
(Address) 700 W. Fairmount Ave

15 Filed JAN 8 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Septicemia due to umbilical infection

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollet, M. D.

1/7. 1930 (Address) 2789 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — DATE OF BURIAL Jan 8 1930

20 UNDERTAKER Joseph A. Oliver — ADDRESS 4024 Harford

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-19-28—L. F. S.—500 Blks.

E 52774 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52774

CERTIFICATE OF DEATH 31

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Meyers 20-69

(a) RESIDENCE NO. 2206 Christian st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 015

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JAN 8 - 1930 H. McSHERRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Jan. 7, 1930, that I last saw him alive on Jan. 7, 1930 and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. C. Arnold, M. D.

1-7-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	1/8/30 19
UNDERTAKER J. J. Fahey & Sons	ADDRESS 1318 Light

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Marie A. Bangert

E 52775

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52775

CERTIFICATE OF DEATH

175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., Ward)

2-FULL NAME Marie A. Bangert

(a) RESIDENCE NO. 309 North Pt. Road, Balto., Co. St., 7-9 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4/1919

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	10	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph H. Bangert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Barbara Kellner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Joseph H. Bangert
(Address) 309 North Pt. Road

15 Filed JAN 8 - 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Food Poisoning
(Source and kind as yet undetermined)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins Hospital

What test confirmed diagnosis?

(Signed) J. H. Hale, M. D.

1/6/30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Jan 11 1930

20 UNDERTAKER Libby & Geiger Inc

ADDRESS 403 S. Wolfe St

Tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52776

CERTIFICATE OF DEATH

74-001 E 52776

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4300 Powell Ave ST., Parkburg WARD) 26-42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adam Droll

(a) RESIDENCE NO. 4300 Powell Ave ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of [redacted] Louisa Droll

6 DATE OF BIRTH (month, day, and year) March 14th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	21	
	74		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 80

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Droll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Droll (wife)

(Address) 4300 Powell Ave Parkburg

15 Filed JAN 9 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Jan 5, 1930, that I last saw h[illegible] alive on Jan 4, 1930, and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Koon, M. D.

1/7, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 9th 1930
20 UNDERTAKER	ADDRESS
Lilly & Gillen Inc	403 S. Wolfe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52777

CERTIFICATE OF DEATH

E 52777

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4400 Belvieu Ave., WARD) 28-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexis P Henry

(a) RESIDENCE NO. 4400 Belvieu Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Henry

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector 086

(b) General nature of industry, business, or establishment in which employed (or employer) Ammunition

(c) Name of employer W S Dept.

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Isaac Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant Adelaide Henry

(Address) 4400 Belvieu ave

15

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/30

17

I HEREBY CERTIFY, That I attended deceased from July 1, 19 27, to Jan 6th, 19 30

that I last saw him alive on Jan 6th, 19 30

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

& Uremia

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) yrs. mos. ds.

(duration) 10 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Wells M. D.

1/8, 1930 (Address) 6 S Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spring Hill Cem Easton Md

DATE OF BURIAL 1-8-30

20 UNDERTAKER Daniel Easton

ADDRESS 716 Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52778

CERTIFICATE OF DEATH

101-001

E 52778

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 596 W. Preston ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Johnson 17-24

(a) RESIDENCE NO. 586 W. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Marr'd

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE: Years 24; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Southern

12 MAIDEN NAME OF MOTHER: Lutheran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Bertha Johnson

(Address) 586 Preston St

15 Filed JAN 8 1930, 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Jan 8, 1930, that I last saw h[illegible] alive on Jan 7, 1930 and that death occurred, on the date stated above, at 4.50 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) [illegible], M. D.

, 19 (Address) 732 Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: 1-8 1930

20 UNDERTAKER: Daniel Foster

ADDRESS 916 Park Ave

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52779 E 52779

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore, Md. — REGISTERED NO. _____

City of BALTIMORE: (No. 619 Archer St., 31-29 (If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond E. Jenkins,

(a) RESIDENCE NO. 619 Archer St. Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Rebecca

6 DATE OF BIRTH (month, day, and year): May 28, 1889

7 AGE: 40 Years 41 | Months 7 — | Days 7 — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Drove a wagon 12 3
(b) General nature of industry, business, or establishment in which employed (or employer): Teamster. —
(c) Name of employer: Mr. Rowe Chestertown Md.

9 BIRTHPLACE (city or town): Chestertown Md.
(State or country): Maryland. —

PARENTS

10 NAME OF FATHER: Sylvester Jenkins

11 BIRTHPLACE OF FATHER (city or town): ?
(State or country)

12 MAIDEN NAME OF MOTHER: Jenkins

13 BIRTHPLACE OF MOTHER (city or town): Chestertown
(State or country): Maryland. —

14 Informant: Mattie Grayson
(Address) 619 Archer St.

15 Filed ..... 19 ..... C. H. ..... M. D.
Registrar
JAN 8 - 1930 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 19 29, to Jan 5, 19 30, that I last saw him alive on Jan 5, 19 30, and that death occurred, on the date stated above, at 1.05 p.m.

The CAUSE OF DEATH* was as follows:
Pulmonary
Cardio - Respiratory Failure

(duration) ..... yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis 4

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum examination

(Signed) Stanley Blake, M. D.

, 19, (Address) 523 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial 1-8 1930

20 UNDERTAKER: Daniel Easton ADDRESS 916 Eutaw

DO NOT WRITE IN THIS SPACE. ALL SHOULD BE STATED. EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

GUNZEMANN ✓

E 52780

HEALTH DEPARTMENT—CITY OF BALTIMORE

139 E 52780

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital for the Insane of Maryland — REGISTERED NO.

CITY OF BALTIMORE: (No. Spring Grove and Asylum ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Gunzeman 9-46

(a) RESIDENCE NO. 1633 Dudley Avenue ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Adam Gunzeman

6 DATE OF BIRTH (month, day, and year) August 1, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad H. Becker

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant William Adam Gunzeman (Husband)

(Address) 1633 Dudley Avenue

15 Filed JAN 8 1930, 19.. [illegible] Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1929, to June 6, 1930, that I last saw h. W alive on June 6, 1930 and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

- post operative.

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Pancystectomy for Mycomatous Uteri (duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Dec. 31, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Bess G. Hodgyce, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 8 1930
20 UNDERTAKER John Ulrich	ADDRESS 2008 Aliceanna

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52781

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 St. Paul ST., WARD) 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edgar F. Kirwan

(a) RESIDENCE NO. 2404 St. Paul St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah P. Greenwood

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	73	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., (State or country) Md.

PARENTS

10 NAME OF FATHER John R. Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann J. Edgar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Edgar F. Kirwan

(Address) 2404 St. Paul St.

15 Filed JAN 8 1930 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1929, to January 7, 1930 that I last saw h. alive on January 6, 1930 and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. M. Kober, M. D.

1/7, 1930 Address 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan. 9, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Milton B. Mitchell

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Kate E. Avery.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52782

CERTIFICATE OF DEATH

44 E 52782

1—PLACE OF DEATH Hospital of the Women of Maryland — REGISTERED NO.

CITY OF BALTIMORE: (No. Lafayette and Linden ST., WARD) 17-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Avery

(a) RESIDENCE NO. 659 West Franklin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julian Williams Avery

6 DATE OF BIRTH (month, day, and year) April 3, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester S.C.

PARENTS

10 NAME OF FATHER Rufus M. Coors

11 BIRTHPLACE OF FATHER (city or town) Tuskegee, (State or country) Alabama

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) Chester (State or country) South Carolina

14 Informant Julian Williams Avery (Husband)

(Address) 659 West Franklin Street.

15 JAN 8 - 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7/30

17 I HEREBY CERTIFY, That I attended deceased from December 26, 1929, to January 7, 1930, that I last saw her alive on January 7, 1930 and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Pyramidal Fibroma

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of pancreas

(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester, S. C.	Jan. 8, 1930
UNDERTAKER John O. Mitchell & Sons Mahlon B. Mitchell	ADDRESS 1900 Eutaw Place

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 52783

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Echodale ave ST., WARD) 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna E. Seitz

(a) RESIDENCE NO. 2901 Echodale ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John G. Seitz

6 DATE OF BIRTH (month, day, and year) April 10th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Alfred Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~St Marys Co~~ Md

12 MAIDEN NAME OF MOTHER Mary A Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edna E Morton

(Address) 2901 Echodale ave

15 Filed JAN 8 - 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 5th, 29, to Jan 7th, 1930

that I last saw her alive on Jan 6th, 1930

and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Sordy, M. D.

1-8, 1930 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan 9th 1930
20 UNDERTAKER	ADDRESS
George Schulling & Sons	1126 Eutaw

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52784 E 52784

CERTIFICATE OF DEATH

75-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., Ward)

2-FULL NAME Charles Dorsey 26-37

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 1930 19 Per C. HAMPSON JONES, M. D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Dec 30

(Signed) H. C. Hudson, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS JAN 3 - 1930

Per Wm. E. WOODALL.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8

Spec.—8-16-29—L. F. S.—100 Bks.

E 52785

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52785

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 W. University Pkwy ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Showell Goldsborough

(a) RESIDENCE NO. 839 W. University Parkway ST. 13-52 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 years yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Phillip Lee Goldsborough

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65 64				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Berlin, (State or country) Md.

PARENTS

10 NAME OF FATHER William Showell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Lafevre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Phillips Lee Goldsborough

(Address) 839 W University Parkway

15 Filed ..., 19... HARRISON JONES, Registrar

N 8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1929, to Jan 7th, 1930, that I last saw h alive on Jan 7th, 1930 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Calc. Endocarditis

" Nephritis

(duration) Centuries

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? C

(Signed) Jefferson Buck, M. D.

1/8, 1930 (Address) 2844 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge, Maryland	Jan. 9, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Madden E. Mitchell

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 52786

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Marshall St. ST., WARD) 24-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard E. Dilworth

(a) RESIDENCE NO. 1428 Marshall st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 5 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Dilworth

6 DATE OF BIRTH (month, day, and year) July 25 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession ar particular kind of work Taxi Dispatcher

(b) General nature of industry, business, or establishment in which employed (or employer) Yellow Cab Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Dilworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ida Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Dilworth

(Address) 1428 Marshall St

15 FILED 8-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 28, to Jan 7, 19 30

that I last saw h.. alive on Jan 6, 19 30

and that death occurred, an the date stated above, at 1:30 AM

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. F. Lawrence, M. D.

1-8, 19 30 (Address) 19 Randall St.

*State the Disease Causing Death, ar in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, ar Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk. Cem.

DATE OF BURIAL 1/9 1930

20 UNDERTAKER J. F. McCully

ADDRESS 130 E. Fort

important. See instructions on back of certificates.

N

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52787

CERTIFICATE OF DEATH.

170 E 52787

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., Ward)

2-FULL NAME Stephen Oliver Bridge. 9-19

(a) RESIDENCE NO. 2006 Boone St. St. Ward

(Usual place of abode) Lifetime.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Dingle Bridge.

6 DATE OF BIRTH (month, day, and year) January 15th. 1864.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stephen Bridge.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary C. Windgate

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Margaret Dingle Bridge.

(Address) 2006 Boone St.

18 Jan 1930 C. RAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7th. 1930. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot in rt temple

(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

1/8/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial 1/9 1930

20 UNDERTAKER Chas. R. Brune & Son ADDRESS 1500 N. Roya[illegible]

Cor.—12-9-25—A Co.—200 Bks.

E 52788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 52788

1-PLACE OF DEATH

City of BALTIMORE: (No. 3213 Montebello Terrace St., Ward)

REGISTERED NO.

2-FULL NAME Augusta E. Wheeler

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 3213 Montebello Terrace St. 27-41 Ward

(Usual place of abode) Lifetime

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William G. Wheeler

6 DATE OF BIRTH (month, day, and year): January 7th. 1858

7 AGE — Years: 71 — Months: 11 — Days: 30 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Family Records,

(Address) 3213 Montebello Terrace,

15 Filed 1930 16 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6th. 1930. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis (Arteriosclerosis-Senile)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) J. H. Collins M. D.
(Coroner)

1/6/30 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Date of Burial 1 9 1930

20 UNDERTAKER: Chas. S. Ward & Son ADDRESS 1210 Druid Royal Ave

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N8

Cor.—12-9-25—A Co.—200 Bks.

E 52789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 188-002 E 52789

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. General Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delia Kyne 16-64

(a) RESIDENCE NO. 2708 Mosher St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Companion

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mr. John Flannagan,

(Address)

15 Filed C. HAMILTON JONES, M. D. Registrar

Jan 8 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7th. 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows

Accident Street Car, Fractured Skull Sudden

(duration) yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Jan 8 1930 C. Hamilton Jones, M. D. (Coroner)

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Mosher & Poplar Sts.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery. Date of Burial: 1/10. 1930

20 UNDERTAKER: Chas. F. Crane & Son ADDRESS 1130 N. Royal Ave

Jan 8 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52790

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52790

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Norton

(a) RESIDENCE NO. 5 Holmhurst Ave Catonsville Md
(Usual place of abode) ST. WARD

Length of residence in city or town where death occurred yrs 6 mos ds. How long in U. S., if of foreign birth? yrs. mos ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE — Years: 43 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicott City Md

PARENTS

10 NAME OF FATHER: John

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cusick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): John J Norton 5 Holmhurst Ave Catons

15 Filed JAN 8 - 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 24th 1929 to Jan 8th 1930.

that I last saw her alive on Jan 8th 1930,

and that death occurred, on the date stated above, at 2 50 p m.

The CAUSE OF DEATH* was as follows:

Hypertension, Chronic Nephritis

Left hemiplegia

(duration) yrs 1 mos 4 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cemetery — DATE OF BURIAL: 1/10/30

20 UNDERTAKER: Lloyd Kaiser — ADDRESS: Laurel Md

IMPORTANT—Should be carefully prepared. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

N8

Spec.—8-16-29—L. F. S.—100 Bks.

E 52791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 52791

27-54

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Mary Baptista Jenkins

(a) RESIDENCE NO. Mount Saint Agnes ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24th 1865

7 AGE: Years 64; Months; Days 13; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Mercy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Thomas W. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Teresa Rachel Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Dave W. Jenkins

(Address): mc Culloh & Archer Sts.

15 8 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Jan. 7, 1930, that I last saw her alive on Jan. 6, 1930 and that death occurred, on the date stated above, at 3:55 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma - primary of breast - with general Metastasis to liver & chest.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1 Sept. 1928

Was there an autopsy? No

What test confirmed diagnosis? Exc. of breast tumor

(Signed) J Leyko, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt St Agnes Convent Cem	Jan 9th 1930
20 UNDERTAKER	ADDRESS
Geo. Jenkins & Sons Co	Exclusive Mc Culloh

OR DEATH in plain terms, so that it may be properly classified. Use only standard abbreviations. Punctuation is not important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52792

CERTIFICATE OF DEATH.

129

E 52792

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4315 Side Hill Rd St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Fritzges 29 66

(a) RESIDENCE NO. 4315 Side Hill Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Fritzges

6 DATE OF BIRTH (month, day, and year): Sept 25 1853

7 AGE — Years: 76 Months: 3 Days: 13 IF LESS than 1 day ..... hrs. or ..... min. 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: John Sussan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Cathon Schleck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Aug Aulbach

(Address): 4315 Side Hill Rd

C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jany 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 1929, to Jany 7 1930, that I last saw her alive on Jany 7 1930, and that death occurred, on the date stated above, at 1025 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yr. ..... mos. 2 weeks

CONTRIBUTORY (Secondary): Toxemia, Pneumonitis

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Turlington, M. D.

19 (Address) 2102 Mt Holly St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

Date of Burial: Jan. 10 1930

20 UNDERTAKER: Margaret D. Flynn

ADDRESS: 1424 Light

8 - 1930

Be sure to carefully explore, AND record in detail EACH of the CAUSES which gave rise to DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52793

CERTIFICATE OF DEATH

101-001

E 52793

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1300 Hull ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin J. McGuire 24-35

(a) RESIDENCE NO. 1300 Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Lang

6 DATE OF BIRTH (month, day and year): Aug 18-1877

7 AGE: Years 52 | Months 4 | Days 19 | If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Michael McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Ellen McGuire Sister.

(Address): 1355 Hull St

15 Filed 8-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1930 to January 6, 1930 that I last saw h alive on January 6, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Chr. Interstitial Nephritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. J. Stevens, M. D.

1-9, 1930 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Jan 9 1930

20 UNDERTAKER: Margaret S. Flynn

ADDRESS: 1422 Light St.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Akehurst 4012 Park Heights

E 52794

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52794

CERTIFICATE OF DEATH

101-001

REGISTERED NO. 15-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3621 Reisterstown Rd ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert E Kinney

(a) RESIDENCE NO. 3621 Reisterstown Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melissa J.

6 DATE OF BIRTH (month, day, and year) July 23rd 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm Kinney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah ?

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant W. C. Kinney

(Address) 3621 Reisterstown Rd

15 Filed JAN 8 - 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1930

17 I HEREBY CERTIFY That I attended deceased from Dec. 29, 1929, to Jan 7, 1930, that I last saw h[illegible] alive on Jan 7, 1930 and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James L. Akehurst, M. D.

1-7-1930 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Belmont, Ohio — DATE OF BURIAL 1/9/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52795

HEALTH DEPARTMENT—CITY OF BALTIMORE

Pierce 2105 E. Chas

E 52795

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Abell Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marshall S. Burdette 12-5

(a) RESIDENCE NO. 3108 Abell Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5th yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clarice

6 DATE OF BIRTH (month, day, and year) Jan 17-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Retail 166

(c) Name of employer Lambert Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clarice Burdette

(Address) 3108 Abell Ave

15 Filed ..... 19 ..... MARION JONES ..... Registrar

JAN 8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 30

17 I HEREBY CERTIFY That I attended deceased from Jan 3 19 30 to Jan 7 19 30

that I last saw h[illegible] alive on Jan 7 19 30

and that death occurred, on the date stated above, at 11 5 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical signs

What test confirmed diagnosis?

(Signed) W H Pearce M. D.

Jan 8. 1930 (Address) 2105 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg W-Va

DATE OF BURIAL 1/10 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Zimmerman 2858 Hartford Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52796

CERTIFICATE OF DEATH

44 E 52796

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1603 E 32nd ST., (WARD) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan R Jackson

(a) RESIDENCE NO. 1603 East 32nd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse Jackson

6 DATE OF BIRTH (month, day, and year): Jan 11, 1860

7 AGE — Years: 69 | Months: 11 | Days: 27 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Abdegruff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Isabelle (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Jennette Brown

(Address) 1603 E 32nd St

15 Filed 1 8 - 1930, 19 — HANSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1927, to Jan 8, 1930, that I last saw h[illegible] alive on Jan 7, 1930 and that death occurred, on the date stated above, at 1:32 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cancer Rectum

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo L Zimmerman, M. D.

1/8, 1930 (Address) 2858 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 1/11 1930

20 UNDERTAKER: D. M. Cook — ADDRESS: 1217 St Paul St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Grace Campbell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52797

CERTIFICATE OF DEATH.

44 ✓ E 52797

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Penn Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Campbell

(a) RESIDENCE NO. 1726 Penn Ave WARD 5-21

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: /

6 DATE OF BIRTH (month, day, and year): Feb 17 66

7 AGE: Years 63 Months 3 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thos. M. Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary M. Trefsel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Robt Campbell

(Address) 1726 Penn Ave

15 Filed 1-10, 1930 C. HAMPSON JONES, M. D. Registrar

N8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/6, 1930, to 1/7, 1930

that I last saw h[illegible] alive on 1/7, 1930

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. Lee Miller, M. D.

1930 (Address) 924 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Frederick

DATE OF BURIAL: 1-9-1930

20 UNDERTAKER: H. C. Cook

ADDRESS: 1217 N Paul St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52798 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 52798

CERTIFICATE OF DEATH

1—PLACE OF DEATH United States Marine Hospital
Baltimore, Maryland

REGISTERED NO. 44

CITY OF BALTIMORE: (No. ____ ST. ____ WARD ____)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Ventura 12-51

(a) RESIDENCE NO. 124 W. 119th St. ST. New York City WARD ____
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 27 ds. How long in U. S., if foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	40	9 8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief cook

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Exermont

9 BIRTHPLACE (city or town) (State or country) Egypt

PARENTS

10 NAME OF FATHER Edmond Ventura

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Adele Mustacchi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Egypt

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Maryland

15 Filed ____, 1930 ____ Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1929, to January 5, 1930, that I last saw him alive on January 5, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma with metastasis in sternum, skull liver and spleen

unknown (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Erysipelas of face done

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ____

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Ralph L Porter, M. D.

1/6/30 (Address) U.S. Marine Hospital, Balto.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Jan. 9, 1929
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52799

CERTIFICATE OF DEATH

90 ✓ E 52799

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 706 Woodington St., Ward)

2-FULL NAME Virginia Warnemuetsch

(a) RESIDENCE NO. 706 Woodington St., 28-71 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Now

6 DATE OF BIRTH (month, day, and year) Nov 5 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	65	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 0/0
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Fred. Warnemuetsch

11 BIRTHPLACE OF FATHER (city or Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Rinehardt

13 BIRTHPLACE OF MOTHER (city or Germany
(State or country)

14 Informant (Address) Lenore Warnemuetsch 706 Woodington

15 [illegible] 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

Jan 6 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL 1/8/1930

20 UNDERTAKER F. A. Hesselbrock ADDRESS 1850 N. Ballo St

IMPORTANT: Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make DIAGNOSIS OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52800 ✓ E 52800

2328 200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 159-002

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2—FULL NAME Estella Haray

(a) RESIDENCE NO. Waterbury ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Louis Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Sarah Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 9 - 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 8 - 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 8, 1930, that I last saw her alive on Jan 8, 1930, and that death occurred, on the date stated above, at 2 15 P- m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Congenital malformation of Rt heart (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) H Bickford jr., M. D.

1/8, 1930 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn a.a Co Md	Jan 9 1930

20 UNDERTAKER R. T. Williams Son

ADDRESS Waterbury Md.

important. See instructions on back of certificates.

Cor.—10-16-29—A Co.—100 Bks.

E 52801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 52801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hospital St. 7-26 (Ward)

2-FULL NAME Henry Reams

(a) RESIDENCE NO. 515 N. Fremont Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
37	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Lexington
(State or country) Ga

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Susie Reams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga

14 Informant Irene Reddick
(Address) 502 N. Calhoun St.

Filed JAN 9 - 1930

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Accidently fell down 2 flgts Fractured Skull

(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

Jan 6 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Jan 9 1930

20 UNDERTAKER Samuel Hemsley ADDRESS 538 N Bradford

Item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52802

CERTIFICATE OF DEATH.

3 1 ✓

REGISTERED NO. E 52802

1-PLACE OF DEATH

City of BALTIMORE: (No. 1119 Harlem St. 16-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Steinbeck

(a) RESIDENCE NO. 1119 Harlem ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year): April 29 1918

7 AGE: Years 11 Months 8 Days 9 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): —

(State or country): Va

PARENTS

10 NAME OF FATHER: Alfred Steinbeck

11 BIRTHPLACE OF FATHER (city or town): —

(State or country): Va

12 MAIDEN NAME OF MOTHER: Alice Powell

13 BIRTHPLACE OF MOTHER (city or town): —

(State or country): N.C.

14 Informant: Mrs. Barrett

(Address): —

Filed JAN 9 - 1930, 19 — CLARENCE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1 8 30 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 19 29, to Dec 8, 19 30, that I last saw h..... alive on Jan 6, 19 30 and that death occurred, on the date stated above, at 4:25 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) ..... yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) John H. Johnson, M. D.

, 19 (Address) 1012 N. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Suffolk Va — Date of Burial: Jan 9 1930

20 UNDERTAKER: Samuel Hensley — ADDRESS: 78 N Bedford

very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

George Ball

HEALTH DEPARTMENT—CITY OF BALTIMORE

52803

CERTIFICATE OF DEATH

X 29 E 52803

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St 15-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Ball

(a) RESIDENCE NO. 1330 Stockton St., Ward Va

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19/1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odo
(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co.,
(State or country) Va

PARENTS

10 NAME OF FATHER Calvin Ball

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Josephine Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Josephine Ball
(Address) 1330 Stockton St

15 Filed JAN 9 - 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus - Accidental discharge of toy pistol 14 days ago.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/9/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Co Melenbeck, Wyt. Va.

DATE OF BURIAL Jan 9 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 52804

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 E. Pratt St., 2-4 WARD)

2—FULL NAME Ida Chiat

(a) RESIDENCE NO. 1415 E. Pratt St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Chiat

6 DATE OF BIRTH (month, day, and year) Fourteen

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Chiat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1439 E. Baltimore St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/30

17

I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1930, to Jan. 9, 1930, that I last saw h.r alive on Jan 9, 12 M 1930 and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Mary Alexander, M. D.

1/9. 1930 (Address) 1705-7 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL 1/9 1930

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Baltimore St

important. See instructions on back of certificates.

JAN - 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52305

CERTIFICATE OF DEATH.

74-002 E 52305

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 13-54

CITY OF BALTIMORE: (No. ..... St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Burdwise

(a) RESIDENCE No. 3416 Auchentroly Terrace St. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 76 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Burdwise

6 DATE OF BIRTH (month, day, and year): December

7 AGE — Years: 53 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Music dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joshua Burdwise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Leurs (Address) 1439 E. Baltimore St

15 Filed JAN 9 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/8 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 8, 1930,

that I last saw him alive on Jan 8, 1930,

and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos. 17 ds. 1

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course & Exam

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Sholom Cem

DATE OF BURIAL: 1/9 1930

20 UNDERTAKER: Jack Leurs 1439 E Baltimore St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52306

CERTIFICATE OF DEATH

90 ✓ E 52306

REGISTERED NO.

1—PLACE OF DEATH Balto City Hospitals

CITY OF BALTIMORE: (No. Balto Md ST. 14-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Strat

(a) RESIDENCE NO. 2130 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE 67 Years	Months	Days	If LESS than 1 day, hrs. or min.
61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer ONO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Street

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records (Address) Balt City Hosp

15 Filed 1-9-1930 H. A. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7-30

17 I HEREBY CERTIFY, That I attended deceased from 6-16-, 1930, to 1-7-, 1930 that I last saw him alive on 1-7-, 1930 and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis

Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry Feldman M. D.

1/7, 1930 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 12 1930

20 UNDERTAKER Sam'l Grace & Son ADDRESS 1420 Madison

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52307

CERTIFICATE OF DEATH.

14-001

REGISTERED NO. E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1319 Winchester St. 16-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Mayo

(a) RESIDENCE No. 1319 Winchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Mayo

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Rob. Harris

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Ellen Harris

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Jessie Mills

(Address) 1319 Winchester St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Jan 7 — 1930, that I last saw h[illegible] alive on Jan 7 — 1930, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley M. D.

1/7 1930 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery DATE OF BURIAL Jan 9 1930

UNDERTAKER Virginia A Brooks ADDRESS 403 N Carey

Filed JAN 9 1930, 19

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

52808 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 52808

CERTIFICATE OF DEATH.

100-007

1-PLACE OF DEATH 601 Pierce St

CITY OF BALTIMORE: (No.) ~~Cordelia Washington~~ 1-No ST. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia Washington

(a) RESIDENCE No. 601 Pierce St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of never married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 47 | Months 0 | Days 0 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer Any body

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Gertrude Holley

(Address) 601 Pierce St

15 Filed JAN 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 7, 1930, that I last saw her alive on Jan 6, 1930 and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos 5 ds.

CONTRIBUTORY (Secondary) none

(duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of ~~~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R B Kenyon, M. D.

1/8, 1930 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 9 1930

20 UNDERTAKER Virginia A Brooks — ADDRESS 1463 N Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52809

CERTIFICATE OF DEATH

170 E 52809

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3900 E. Patt. St., 26-37 Ward)

2-FULL NAME Alfonso Santoni

(a) RESIDENCE NO. 3900 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Giacinta Santoni

6 DATE OF BIRTH (month, day, and year): June 16, 1876

7 AGE: Years 53 | Months 5 | Days 21 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: B & O. R.R

0157

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Carolino Santoni

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Alfred Santoni
(Address): 3900 E. Pratt st

15 Filed JAN 9 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot of Chest.
(duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Shock
(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. C. Stadler, M. D.

(Address) 1436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 10 1930

20 UNDERTAKER: Frank V. Pisitano — ADDRESS: 2918 E. Baltimore

(Not to be filled in by physicians. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52810 — CERTIFICATE OF DEATH — 159-802 E 52810

1—PLACE OF DEATH Union Memorial Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 33d + Calvert ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris Griffith

(a) RESIDENCE NO. 4719 Old York Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1929

7 AGE — Years: 0 | Months: 8 | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Roberta Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mother
(Address) 4719 Old York Road

Filed JAN 9 1930 C. HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930 to Jan 6, 1930

that I last saw h[illegible] alive on Jan 6, 1930

and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Congenital Anomaly of Heart

(duration) yrs. 8 mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) William Edward Lorden M. D.

Jan 6th 1930 (Address) Union Memorial Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL Jan 9th 1930

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52811

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital - Aradelphia 3-5 St., Ward)

2-FULL NAME Schein

(a) RESIDENCE NO. 908 E. Lombard St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W.	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
5			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boy/child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

Filed JAN 9 - 1930 Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coroner's Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accident

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Coroner's Jury, Coroner, M. D.

, 1930 (Address) 606 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 9 - 1930

For Rm. E. Woodall

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52812

John Wilkerson

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 52812

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 100 Front St St. 5-8 Ward)

2-FULL NAME John Wilkerson

(a) RESIDENCE NO. 100 Front St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 9 - 1930 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Whitney Evans, M. D.

Jan 9 1930 (Address) 1609 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
THE MORGUE

DATE OF BURIAL 19
JAN 9 - 1930

20 UNDERTAKER
Commissioner of Health.

Per. Wm. S. Rogers

FILL SHOULD BE CAREFULLY SUPPLIED. AGE, SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52813

CERTIFICATE OF DEATH.

3 ✓ E 52813

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 N Durham St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Heralage

(a) RESIDENCE NO. 415 N. Durham St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: 20 Months: Days: IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): O'S

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER Lizzie White

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Lauer N C

14 Informant:

(Address)

15 Filed ..... 19 ..... Registrar.

9215

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 6/30.

17

I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1930, to one call, 19....., that I last saw h... alive on Jan 4th, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Janke, M. D.

, 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Hospital Date of Burial 1-6-30

20 UNDERTAKER: Geo. F. Kirk ADDRESS 1735 Harford Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 52814

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: No. Eaton & Wilkens Ave ST. 25-66 WARD

2-FULL NAME ~~Baby Boy~~ John Jackson Irving Pumphrey

(a) RESIDENCE NO. 909 Cooks Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 5, 1930

7 AGE — Years: ~~3 days~~ — Months: — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Jackson Irving Pumphrey

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Irene Rhae Redifer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant: Jackson Irving Pumphrey

(Address) 909 Cooks Lane

15 Filed JAN 9 1930 C. HAMPTON CONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 8 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-5, 1930, to 1-8, 1930, that I last saw h[illegible] alive on 1-8, 1930, and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen M. D.

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jan 9 1930

20 UNDERTAKER: Wm J Fickner Sons ADDRESS: North & Pa

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52815

CERTIFICATE OF DEATH

118-001 E 52815

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 1014 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edwin Anderson

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 13 Dec. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Andries Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston + Valley Sts

15 Filed 1930 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from 12/15, 1929, to 1-8, 1930, that I last saw h alive on 1-7, 1930, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inguinal Hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Bernard Wess M. D.

1/9, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 9 1930

20 UNDERTAKER Rita Wiedefeld ADDRESS 914 Greenmt Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52816

CERTIFICATE OF DEATH

E 52816

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital) (ST. or AVE.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ELIZABETH BAILEY

(a) RESIDENCE NO. 1026 Stockton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 6 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Bessie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Bessie Bailey

(Address) 1026 Stockton St.

15 Filed JAN 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to Jan 8, 1930, that I last saw h er alive on Jan 7, 1930 and that death occurred, on the date stated above, at 2 15 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary) Streptococcus Septicemia

Acute Nephritis (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? 1026 Stockton St

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Ashby, M. D.

1-8, 1930 Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Jan. 10 1930

20 UNDERTAKER H. J. Locks

ADDRESS 1302 Jefferson St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospitals St., (Ward)

2-FULL NAME Russell Baskerville

(a) RESIDENCE NO. 15½ Amity St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lulu Baskerville

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) Mackenburg, (State or country) Va.

PARENTS

10 NAME OF FATHER James Baskerville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lulu Baskerville
(Address) C. Hartlow, 15½ Amity St.

Filed JAN 9 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Pellagra

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) St. Louis Fever

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What findings confirmed diagnosis? Typical findings

(Signed) C. V. Glades, M. D.

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakecross, Va	Jan 9, 1930
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	322 N Schroeder St.

Now should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52818

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52818

CERTIFICATE OF DEATH

89

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Highfield Road ST.) 12-44 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John P. Lauber

(a) RESIDENCE NO. 5 Highfield Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora B. Lauber

6 DATE OF BIRTH (month, day, and year) Jan. 10-1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President 86

(b) General nature of industry, business, or establishment in which employed (or employer) Central Fire Ins Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip J. Lauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Weiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Cora B Lauber

(Address) 5 Highfield Road

15 Filed [illegible] Registrar

[illegible]-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1930, to Jan 8 1930, that I last saw h[illegible] alive on Jan 8 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(2d attack)

Jan 8

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. da.

Jan (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C B Lenhart, M. D.

19 (Address) 1417 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan. 11 1930
20 UNDERTAKER Chas. E. Franck	ADDRESS 702 Madison Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52819

CERTIFICATE OF DEATH

3/ E 52819

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 23-31 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Miller

(a) RESIDENCE NO. 1137 Race st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carol ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 FILED 1-9-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Jan. 8, 1930, that I last saw him alive on Jan. 8, 1930 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thurston Jr, M. D.

1-8, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 1-12 1930

20 UNDERTAKER Ernest Rice

ADDRESS Homestead

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52820

CERTIFICATE OF DEATH

3 ✓ E 52820

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Jackson

(a) RESIDENCE NO. 633 N. Central ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER William H. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mattie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records

(Address)

15 Filed 1930, 19 HAMSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 20, 19 29 to Jan. 4, 19 30, that I last saw him alive on Jan. 4, 19 30 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Grinald Jr, M. D.

1-4-, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JAN 9 - 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

Important. See instructions on back of certificate.

Gov. Print. Office

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52821

CERTIFICATE OF DEATH

90 ✓ E 52821

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 21-31 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Jackson

(a) RESIDENCE NO. 923 S. Fremont ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S. if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER William Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant Hospital Records

(Address)

15 Filed 1-9, 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1929, to Jan. 3, 1930, that I last saw him alive on Jan. 3, 1930 and that death occurred, on the date stated above, at 7.50 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute and chronic myocarditis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas F Arnold Jr M. D.

1-3 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JAN 9 - 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 52822

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52822

CERTIFICATE OF DEATH

7H-061

1-PLACE OF DEATH West Balto Gen. Hospital

CITY OF BALTIMORE: (No. Balto. Md St. 15-5X (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M Pfeisterer (Pfisterer)

(a) RESIDENCE No. 3414 Park Heights Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (Margaret C. Schultze)
HUSBAND of (or) WIFE of Mrs F. M Pfeisterer

6 DATE OF BIRTH (month, day, and year) — 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinery Broker

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mr Pfeisterer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mrs Pfeisterer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Pfeisterer

(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

N9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 9 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 7 - , 1930, to Jan 9 , 1930,

that I last saw h[illegible] alive on Jan 9 - , 1930

and that death occurred, on the date stated above, at 6.07a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY? (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Spinal Puncture~~ Physical exam

(Signed) J. P. Costagna, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1/11 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

CAUSE OF DEATH TO BE PRINTED, SO THAT IT MAY BE PROPERLY CLASSIFIED. PRINT NAME IN FULL.

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 352823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 84 E 52823

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert C. Jones

(a) RESIDENCE NO. Hamilton-Ohio. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Joseph Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio. Md.

12 MAIDEN NAME OF MOTHER Sydney Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... THOMPSON JONES, M. D. Registrar

JAN 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8-30.

17 I HEREBY CERTIFY, That I attended deceased from 12/31 - 1929, to 1-8-1930, that I last saw h... alive on 1-5-1930 and that death occurred, on the date stated above, at 10 19 A. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Hypophyseal Adenoma. (Benign)

(duration) 2½ yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 4, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence E. Gardner Jr. M. D.

1/9, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hamilton Ohio	1/8/30
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52824 — 100-001 — E 52824

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1000 Caton Ave ST., 20-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona E. Malkemus

(a) RESIDENCE NO. 28 South Pentalon ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	5 6	30 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Malkemus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hafnith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant (Address) Jenkins Memorial Hosp

15 Filed 9-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1930, to Jan. 8, 1930, that I last saw h alive on Jan 8, 1930 and that death occurred, on the date stated above, at 8-40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brewer M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Redeemer Cem 1/10/30

20 UNDERTAKER — ADDRESS

Enoch & Staley Fulton & Fayette

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 52825

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO. 26-37

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Lapin

(a) RESIDENCE NO. 6720 Trappe Road ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? Unknown yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879 (1880)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Fred Lapin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Caroline Eder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records
(Address)

15 Filed 9 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1929, to Jan. 7, 1930, that I last saw him alive on Jan. 7, 1930 and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of the bronchus with metastases.

(duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Thorold R. M. D.

1-8-1930 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Jan. 10, 1930

20 UNDERTAKER Henry Sander & Sons, Inc. — ADDRESS Baltimore St & Broadway

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52826 HEALTH DEPARTMENT—CITY OF BALTIMORE 4 52826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Volunteer Hospital ST. 7933 WARD

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kline

(a) RESIDENCE No. 1022 Patapsco ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred about 75 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philipine Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Louise G. Bowers
(Address) 3626 Roland Ave

15 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 1 - 8, 1930, to 1 - 8, 1930, that I last saw h[illegible] alive on 1 - 8, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. F. Conrey, M. D.

1 - 9, 1930 (Address) Vol. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys (Hampden)	Jan. 10 - 1930
20 UNDERTAKER Horace H. Burgee	ADDRESS 603 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 9 - 1930

Cor.—12-9-25—A Co.—200 Bks.

(Plassil)

E 52827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 52827

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4706 Parkhurst 27-16 St. Ward

2-FULL NAME Anna E. Plassil

(a) RESIDENCE NO. 4706 Parkhurst St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 1 — 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Bohemia

10 NAME OF FATHER — Kolmagnick

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Bohemia

PARENTS

14 Informant Mrs Joseph Higdon

(Address) 4706 Parkhurst Ave.

15 1930 C. HAMPSON JONES, Registrar

By _____

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Thomsen M. D.

(Coroner)

1/9, 1930 (Address) 1632 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem — Date of Burial: Jan-10-30

20 UNDERTAKER: Geo. W. Tuttle — ADDRESS 2700 Edmondson Ave.

E 52828

HEALTH DEPARTMENT—CITY OF BALTIMORE

403

V 52828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital 188

CITY OF BALTIMORE (No. 33 " Calvert ST. 11-24 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Dudley Riggs Jr

(Residence in Baltimore: No. 814 N Carrollton Av St.; V. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 28 (Month) (Day), 1898 (Year)

7-AGE. 31 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country), Conn. Hartford ~~Co Md~~

PARENTS.

10-NAME OF FATHER, Thomas D. Riggs

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Laura Lowman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospitals Record

(Address)

15-

Filed 1930

C. HAMPSON JONES, M. D.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9 (Month) (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptd Spleen - Ruptd Leg with fam. as compound comminuted

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Pelvis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)
1/9, 1930 (Address) 2439 N Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Park Heights Ave & Coun Road

Former or usual residence 3 Weeks from Florida

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Jan. 11, 1930

20-UNDERTAKER Henry Wenkens Son ADDRESS Eutaw & Lexington

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52829

CERTIFICATE OF DEATH.

E 52829

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enrouted to 100 E 20th St 25-75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Clayton Kramer Jr.

(a) RESIDENCE No. Ballman Ave ST. A.A. Co. Brooklyn WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 12, 1929

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ballman Ave A.A. Co. Md

PARENTS

10 NAME OF FATHER Howard C Kramer

11 BIRTHPLACE OF FATHER (city or town) Landsdowne (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Sophia Ballman

13 BIRTHPLACE OF MOTHER (city or town) A.A. Co. Md (State or country)

14 Informant Walter C Bacon (Address) 100 E 20th St

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1929, to Jan 9, 1930, that I last saw him alive on Jan 7, 1930, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

(over)

1a Bronchio Pneumonia

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? Ballman Ave A.A.Co

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Walter C Bacon, M. D.

1/9, 1930 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 1/11/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Cem. 0101

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52830

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74 E 01 52830

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital) (STREET 8-17 WARD)

2-FULL NAME Mrs. Catherine Folker.

(a) RESIDENCE NO. 1827 Register St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E Folker

6 DATE OF BIRTH (month, day, and year) Sept 4, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43	43	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER William Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Lucinda Buckholder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary M. Kelly

(Address) 1827 N. Register St

15 C. RAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929 to Jan 8 1929.

that I last saw her alive on Jan 8 1929,

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 12-21-29

Was there an autopsy? no (over)

What test confirmed diagnosis? Clinical

(Signed) M B Hendrix M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Ignatius Cemetery Hickory Md

DATE OF BURIAL 1/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

19 - 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 52831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 52831

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ronald Callahan

(a) RESIDENCE NO. 2847 Huntington Ave ST., Balto Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15, 1929

7 AGE	Years	Months	Days 23	If LESS than day, hrs. min.
			24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Austin Callahan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Alban

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Aunt Mrs. Edgar V. Alban
(Address) 5422 N. 37th St.

15 Filed JAN 9 1930, 19 C. HAMILTON JONES, M. D. Registrar
Pct

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 8, 1930, that I last saw him alive on Jan 8, 1930 and that death occurred, on the date stated above, at 7 25 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Pulmonary edema due to 23 hrs
Circulatory collapse (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William R. Swartzbaugh M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Mary's Cem. Hampden — Jan 10, 1930

20 UNDERTAKER — ADDRESS

Harry N. Weitzel 440 Edmondson Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52832

CERTIFICATE OF DEATH

52 E 52832

1—PLACE OF DEATH ~~Home~~ Homewood Cemeteries REGISTERED NO. 26-47

CITY OF BALTIMORE: (No. 40th & Cedar Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ~~Hobe~~ Dorset Samuels

(a) RESIDENCE NO. 4804 Richard Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Samuels

6 DATE OF BIRTH (month, day, and year) Mar. 10, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49		9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Ormiston (State or country) Scotland

10 NAME OF FATHER John Dorset

11 BIRTHPLACE OF FATHER (city or town) Ormiston (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Anderson

13 BIRTHPLACE OF MOTHER (city or town) Perth (State or country) Scotland

14 Informant Isaac Samuels (Address) 4804 Richard ave

15 Filed 9-1930 C. HAMPSON JONES M. D. Registrar DKR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1929 to Jany 7, 1930 that I last saw her alive on Jany 6, 1930 and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam.

(Signed) W W J Mayo, M. D.

Jan 7 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glendye Cem.	1/10/30
20 UNDERTAKER Harry A Witzke	ADDRESS 4601 Edmondson ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

(Janish)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52833 — CERTIFICATE OF DEATH — E 52833

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Hospital ST., 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Mary Janish

(a) RESIDENCE NO. Laurel Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harold Janish

6 DATE OF BIRTH (month, day, and year): June 23 1900

7 AGE: Years 29 | Months 6 | Days 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Laurel Md

PARENTS

10 NAME OF FATHER: John Band

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Bartlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Floyd Kaiser

(Address): Laurel

15 Filed ....., 19 ..... A.M. ..... P.M. ..... Registrar

NO - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/1/30

17 I HEREBY CERTIFY, That I attended deceased from 1-8 1930, to 1-9 1930, that I last saw h[illegible] alive on 1/9/30, and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Eclampsia Gravidarum

(duration) ....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. Samuel Straughn, M. D.

19 (Address) Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md

DATE OF BURIAL: 1/11/30

20 UNDERTAKER: C. Floyd Kaiser

ADDRESS: Laurel Md.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52834 — 57 — E 52834

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 4644 Park Heights Ave ST., 57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Carroll

(a) RESIDENCE NO. 3849 Rolandave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Emma E. Carroll

6 DATE OF BIRTH (month, day, and year) May 19 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Police
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS
10 NAME OF FATHER Lafkin Carroll
11 BIRTHPLACE OF FATHER (city or town) (State or country) So Carolina
12 MAIDEN NAME OF MOTHER Elizabeth Wiener
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Mrs. Helen J. Duffy
(Address) 3849 Roland Ave

15 Filed JAN 10 1930 E. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1927, to January 8, 1930, that I last saw h.~~im~~ alive on January 8 1930 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Endocarditis
Cerebral Apoplexy
Diabetes Mellitis (duration) ....yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Fenty H. Meade, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carroll's Mount Olivet Branch — DATE OF BURIAL: Jan 11 1930

20 UNDERTAKER: A. S. Marshall — ADDRESS: 3539 Falls Road

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

52835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 52835

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gel Hospital ST. 17-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lottie A. Miller

(a) RESIDENCE NO. 2210 N Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) V

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Andrew J Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Harriett Spahr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Mildred Lyon Warren

(Address) 2210 N. Calvert St

15 Filed JAN 10 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9-1930

17 I HEREBY CERTIFY, That I attended deceased from October 29, 1929, to Jan. 9, 1930, that I last saw her alive on Jan 9, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) 2nd attack Jan. 8-1930

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) C. F. Robinson, M. D.

Jan 15 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Jan 10 1930

20 UNDERTAKER Wm. Cottle

ADDRESS 1217 St Paul St

Important: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 52336

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Ruscheet Ave ST. Mayfield WARD 27-44)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily S. Hartley

(a) RESIDENCE NO. 2907 Ruscheet Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbert Hartley

6 DATE OF BIRTH (month, day, and year) July 26 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Charles H Penn.

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary E Dunn

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Wilbert Hartley (Address) 2907 Ruscheet Ave

15 Filed JAN 6 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14. 1929 to Jan 5. 1930.

that I last saw h alive on Jan 5 1930

and that death occurred, on the date stated above, at 10 20 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pharynx & Lung

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Chas Emrich M. D.

1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friends Cemetery — DATE OF BURIAL 1/10 1930

20 UNDERTAKER Wm Cook — ADDRESS 127 St Paul St.

CAUSE OF DEATH MUST BE FILLED IN, SO THAT IT MAY BE PROPERLY CLASSIFIED. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52837 129 ✓

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1653 N. Appleton ST. 15-7 WARD) REGISTERED NO. E 52837

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Goldstein

(a) RESIDENCE NO. 1653 N. Appleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Goldstein

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hebrew Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Joseph Goldstein

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hanton

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant Jack Louis

(Address) 1429 E. Baltimore St.

FILED JAN 10 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/30

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1929, to Jan. 9th, 1930, that I last saw h in alive on Jan. 9th, 1930 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

General arterio Sclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? 2.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) R.G. Nicholson, M. D.

Jan 9, 1930 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Rest

DATE OF BURIAL 1/10 1930

20 UNDERTAKER Clark Lewis

ADDRESS 1432 E. Balto St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52838

CERTIFICATE OF DEATH

11-002

11 E 52838

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1633 Gorsuch Av ST., 9-46 (WARD)

2—FULL NAME Susanna Krauss.

(a) RESIDENCE NO. 1633 Gorsuch Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Krauss.

6 DATE OF BIRTH (month, day, and year) May 25 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	78	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Jacob Frederick

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Margaret Krauss

(Address) 1633 Gorsuch Av

15 Filed JAN 10 1930, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7-1930

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1930, to Jan 7, 1930, that I last saw h alive on Jan 7, 1930 and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Decompensated)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. F. A. Stevens, M. D.

1-8, 1930 (Address) 2978 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	Jan. 10 1930
20 UNDERTAKER Henry Hauch Sons, Inc.	ADDRESS 1501 E Eager St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 52839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52839

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2523 E. Biddle ST. 8-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James. A. Carmine

(a) RESIDENCE NO. 2523 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 21 ds. How long in U. S., if foreign birth yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 17 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 067

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William. A. Carmine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret. J. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr Elsie. M. White.

(Address) 2523 E. Biddle St

15 Filed JAN 10 1930, 19

C. HAMILTON JONES, M. D.
Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 8 - 1930

17 I HEREBY CERTIFY That I attended deceased from Dec 6, 1929 to Jan 8, 1930

that I last saw h living alive on Jan 8, 1930

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Exam.

(Signed) Louis T. Levy, M. D.

Jan 9 1930 (Address) 1740 W. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 12 1930
20 UNDERTAKER	ADDRESS
Henry Houck & Sons	1301 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52340

CERTIFICATE OF DEATH

170 VE 52340

1-PLACE OF DEATH

City of Baltimore: (No. W. B. Gen Hosp) ... St. 28-6 Ward

2-FULL Geo W. Haynes

(a) RESIDENCE NO. 2601 Laurina Rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie

6 DATE OF BIRTH (month, day, and year) 1868 July 19

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	61	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mass.
(State or country)

PARENTS

10 NAME OF FATHER Geo W. Haynes

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Emma Conway

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Lillie Haynes
(Address) 2601 Laurina Rd

15 Filed ... 19... C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to pistol wound of brain

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Suicide

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 1/11/1930

20 UNDERTAKER Geo Weber Sr — ADDRESS 2503 Edmondson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 13 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 52341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 52341

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4215 Potter ST. 20-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christine Roth

(a) RESIDENCE NO. 4215 Potter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Louis C. Roth

6 DATE OF BIRTH (month, day, and year) Jan 22/1865

7 AGE Years	Months	Days	If LESS than 1 day... hrs. or... min.
64	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) / 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Frank B. Steele

(Address) 4215 Potter Street

15 FILED NOV 10 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1930

17 I HEREBY CERTIFY That I attended deceased from Nov 1, 1929 to June 9, 1930 that I last saw her alive on June 9, 1930 and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) L. A. Kelly M. D.

. 19 (Address) 3517 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 11/13/1930

20 UNDERTAKER Gw. Weber & Son — ADDRESS 2503 Edmondson

IMPORTANT: See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 52842

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 Penrose Ave ST.) (WARD) 90-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie E. Miller

(a) RESIDENCE NO. 2233 Penrose Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 8 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 26th 1916.

7 AGE: Years 13. Months 8. Days 13. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Albert F. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Blanche Mauer Seidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Albert F. Miller

(Address) 2233 Penrose Ave

15 Filed JAN 6 1930 HAMILTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929, to Jan 8, 1930, that I last saw h alive on Jan 6, 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) mos. 1 da.

(duration) yrs. 11 mos. 20 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jas H Chamberlain M. D.

(Address) 1729 K Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jan 11th 1930

20 UNDERTAKER: Robert Cowan & Son ADDRESS: 901 Hollins St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52843 HEALTH DEPARTMENT—CITY OF BALTIMORE. E 52843

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital ST., 14 WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Lloyd

(a) RESIDENCE NO. 2212 N McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life's mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jesse Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ann Lloyd

(Address) 2212 McCulloh St

Filed 1 3 1930, 19 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8/30 19

17 I HEREBY CERTIFY, That I attended deceased from 1/5/30, 19 to 1/8/30, 19, that I last saw him alive on 1/8/30, 19, and that death occurred, on the date stated above, at 9:08 P. m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. M. Lambert, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 1-11-30

20 UNDERTAKER Rund Estate ADDRESS 946 Penn

• CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52844

CERTIFICATE OF DEATH

E 52844

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 589 Greenmount St., 7-24 Ward) 112

2-FULL NAME Walter Reed

(a) RESIDENCE NO. 589 Greenmount St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Thos. Reed
(Address) 613 Penna Ave

15 Filed JUN 10 1930 C. HAMILTON JONES, M. D., Registrar
By RAH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) hrs.

CONTRIBUTORY (Secondary) Error of Diet Sudden

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis?

(Signed) June 7th F. Regular Leitch Coroner, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL June 10 1930

20 UNDERTAKER David Eustain ADDRESS 816 Park Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52845

CERTIFICATE OF DEATH

EX 52845

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 N. Mo. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Jackson

(a) RESIDENCE NO. 578 N. Mo. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Louis Coleman

(Address)

15 Filed JAN 10 1930 19 C. Hampton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 8, 1930, that I last saw h[illegible] alive on Jan 8, 1930 and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows:

1a. Pneumonia

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease Contributory

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) R. Garland Schmidt, M. D.

Jan 9. 1930 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	1-11-1930
20 UNDERTAKER Hand Eastern	ADDRESS 916 Eutaw.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52846

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 N Franklin ST.) (E - 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry G Jones

(a) RESIDENCE NO. 912 N Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara M Jones

6 DATE OF BIRTH (month, day, and year) Nov 24 63

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paver.

(b) General nature of industry, business, or establishment in which employed (or employer) Street Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry G Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) at Sea England Wales

12 MAIDEN NAME OF MOTHER Henrietta Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Barbara Jones

(Address) 912 N Franklin

15 Filed JAN 10 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 30

17 I HEREBY CERTIFY, That I attended deceased from December 15, 1929, to Jan 8, 1930, that I last saw h. alive on Jan 7, 1930 and that death occurred, on the date stated above, at 12:00 Noon

The CAUSE OF DEATH* was as follows:

Cerebral & Pulmonary Influenza.

(duration) — yrs. — mos. 27 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) — yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Chester Riland, M. D.

1-9-, 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 11 1930
20 UNDERTAKER	ADDRESS
W M. Routson	2258 W Baltimore

important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52847

99-001

E 52847

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital) (Ward) 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron M. Arlett

(a) RESIDENCE NO. 505 S. Paca St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Oct 5 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
✓	73	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Centerville

(State or country) Md.

PARENTS

10 NAME OF FATHER Aaron M. Arlett

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary H. — ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hospital Records

(Address)

15 Filed JAN 10 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929 to Jan 9, 1930

that I last saw him alive on Jan 9, 1930

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows: 1a

Peri rectal Abscess and Bronchitis (acute)

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema chest

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 1-8-1930

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S K Wells, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Centerville Md.	Jan 12 1930
20 UNDERTAKER Charles F. Gill.	ADDRESS 3109 Frederick Ave.

NOTICE TO CARING APPARTE AND should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52848

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Etting ST. 14-20 WARD)

2—FULL NAME Cornelius B Burrell

(a) RESIDENCE NO. 1831 Etting ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret D. Burrell

6 DATE OF BIRTH (month, day, and year) Mch 3rd 78

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	57	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work O&O

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) Hampton (State or country) Va

PARENTS

10 NAME OF FATHER Peter Burrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margaret D. Burrell

(Address) 1831 Etting St

15 JAN 10 1930 HAROLD J. JONES M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to Jan 9, 1930, that I last saw h.... alive on Jan 9, 1930 and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) B. N. Halpin M. D.

1/10, 1930 (Address) 1776 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hampton Va	Jan 11th 1930
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1400 Mosher

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52849

CERTIFICATE OF DEATH

101-001

E 52849

1—PLACE OF DEATH President Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division St. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Elbert Jr

(a) RESIDENCE NO. 432 N Fremont AVE. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Elbert

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md

PARENTS

10 NAME OF FATHER John Elbert

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Martina Wheeler

13 BIRTHPLACE OF MOTHER (city or town) Dorchester (State or country) Co. Md

14 Informant Mary Elbert (wife)

(Address) 432 N Fremont Ave

15 Filed 19 Registrar

N 1 01930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9. 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 9, 1930, that I last saw h alive on Jan 9, 1930 and that death occurred, on the date stated above, at 5.20 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

19 (Address) President Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hurlock Md	Jan 10 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Presstman St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 52850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

E 52850

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1363 Gilmore ST. 45-22 WARD)

2-FULL NAME Viola Carroll

(a) RESIDENCE NO. 1363 Gilmore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5 1894

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min
36	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Washing & Ironing

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bath

PARENTS

10 NAME OF FATHER: Milton Sales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bettie Jones

(Address) 1363 Gilmore St.

15 FEB 1930

16 H. [illegible] JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 8 — 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 4th 1930, to Jan 8 1930, that I last saw h alive on Jan 6 1930, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Jos Carter, M. D.

19 (Address) 1433 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary

DATE OF BURIAL: June 10 1930

20 UNDERTAKER: Wm. J. A. Elliott

ADDRESS 1725 Pennsylvania Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 52851

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2619 N. Charles ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Stewart Crise

(a) RESIDENCE NO. 2619 N Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard L Crise

6 DATE OF BIRTH (month, day, and year) May 30 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edwin E Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Billers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard E. Crise

(Address) 2619 N Charles St

15 Filed JAN 10 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Jan 8, 1930, that I last saw her alive on January 8th, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Femur (metastatic)

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) Herbert M. Foster, M. D.

, 19 (Address) 928 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan 11 1930
UNDERTAKER John O Mitchell Son	ADDRESS 1918 Eutaw Pl

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52852

CERTIFICATE OF DEATH

44 ✓

E 52852

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2718 Maryland Ave. ST. 17-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Bertha Kesmodel

(a) RESIDENCE NO. 2718 Maryland Ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 21 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin M. Kesmodel

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1880

7 AGE	Years	Months	Days 20	If LESS than 1 day, ...hrs. or ....min.
	49	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Myohl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schuster

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Edwin M. Kesmodel
(Address) 2718 Maryland Avenue

15 FILED JAN 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929 to Jan. 8, 1930

that I last saw h[illegible] alive on Jan. 8, 1930

and that death occurred, on the date stated above, at 9.35 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma, stomach and liver.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dodemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical signs + lab.

(Signed) C. Watson Bunch, M. D.

1/10 1930 (Address) 817 Park Ave. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	1/11 1930

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52853

CERTIFICATE OF DEATH

188-103 E 52853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp St. 6-10 Ward)

2-FULL NAME Geo Mumsleman

(a) RESIDENCE NO. 428 N Lakewood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louise

6 DATE OF BIRTH (month, day, and year) Oct 22 - 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	2	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Patn Cl
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) Dont know
(State or country)

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) Dont know
(State or country)

14 Informant Rosina Mumsleman
(Address) 428 N Lakewood ave

15 Filed JAN 10 1930, 19 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Ruptr. Splen
Struck & knocked down
by automobile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Rib Cranial with
Lac. Neuroma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lakewood & Eutaw

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Surg & Autopsy

(Signed) H Frank

1/9, 1930 (Address) 2439 Mc Elderry, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	Jan 10, 1930
20 UNDERTAKER John Ulrich	ADDRESS 2008 Aliceanna

IMPORTANT—Physician is expected to fill out this certificate in every particular. Information must be complete and satisfactory. Space should be filled with typewriter or pen and ink. Use lead pencil only when absolutely necessary. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Use plain terms, so that it may be properly classified.

Spec.—8-16-29—L. F. S.—100 Blks.

732809
E 52854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-001 E 52854

1—PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST. 711 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Nierhaus

(a) RESIDENCE NO. 1241 N. Potomac ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov-24-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Date received JAN 10 1930 H. BOX JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-8-30

17 I HEREBY CERTIFY, That I attended deceased from Dec-18, 1929, to Jan 8, 1930, that I last saw h. alive on Jan 8, 1930 and that death occurred, on the date stated above, at 6 10 p. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 2½ hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-7-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Ridgeway Trimble M. D.

Jan 9 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Jan 10 1930

20 UNDERTAKER John Ulrich

ADDRESS 2108 Belair

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52855

CERTIFICATE OF DEATH

1-DE 52855

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Baker

(a) RESIDENCE NO. 9 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	23	9	19	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel E. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Streck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Milton Streck

(Address) 9 S. Linwood ave

15 Filed JAN 10 1930 MAYNARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-31- 1929 to 1-8 1930, that I last saw h[er] alive on 1-8 1930 and that death occurred, on the date stated above, at 3:10 P.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis F. Gundry M. D.

1-8 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cemetery	Jan 11 1930
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

52856

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52856

100-002

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 S. Ellwood Ave ST 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Hartman

(a) RESIDENCE NO. 917 S. Ellwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 9-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	—	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. F. Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rose Deaves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Rose Hartman

(Address) 917 S. Ellwood ave

15 Filed JAN 10 1930 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9-1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19....., that I last saw h... alive on ....., 19....., and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Jan 11 1930
UNDERTAKER George W. Zinkler	ADDRESS 1737 E. Eager St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52857 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH.

161-001 E 52857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 615 Willow ave ST., 27-48 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Eugene John Wagner

(a) RESIDENCE NO. 615 Willow ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 2 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) 615 Willow ave
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James A Wagner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary G O'Rourke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant James Wagner
(Address) 615 Willow ave

15 Filed JAN 10 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1930 to Jan 9 1930, that I last saw him alive on Jan 9 1930, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:
Premature Birth

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Hoes, M. D.

1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 10 1930

20 UNDERTAKER Thos Wood & Son

ADDRESS 3 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 10 1930

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52858

CERTIFICATE OF DEATH.

129 E 52858

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 E. Eager St. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Doyle

(a) RESIDENCE NO. 924 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 5, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Niece Mrs. Ellen M. Conklin

(Address) 924 E. Eager St

15 Filed JAN 10 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to Jan 8, 1930, that I last saw h[illegible] alive on Jan 8, 1930, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Ch nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

1/9, 1930 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan. 11 1930

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 424 E Eager

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52859

CERTIFICATE OF DEATH

57 √E 52859

1-PLACE OF DEATH

REGISTERED NO. 14-26

City of BALTIMORE: (No. Maryland Gen. Hosp. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Harrison.

(a) RESIDENCE NO. 412 W. Fulton St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Wilber Harrison.

6 DATE OF BIRTH (month, day, and year): Aug 17, 1862

7 AGE: Years 67 Months 4 Days 22 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md.

PARENTS

10 NAME OF FATHER Stingers

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Briden

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Hospital Records

(Address)

JAN 10 1930 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9 19 30

17 I HEREBY CERTIFY, That I attended deceased from 1/5/30, 19..., to 1/9/30, 19...,

that I last saw her alive on 1/9/30, 19...,

and that death occurred, on the date stated above, at 6.05 p.m.

The CAUSE OF DEATH* was as follows:

Diabetis

Diabetic gangrene L.L. foot,

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. 1 mos. da.

18 Where was disease contracted

if not at place of death? Home.

Did an operation precede death? No Date of 1/1/30

Was there an autopsy? No Autopsy

What test confirmed diagnosis? Clinical

(Signed) J. A. Thompson, M. D.

, 19 (Address) 1 W. Fayette

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Jan 11 1930

20 UNDERTAKER: George J. Smith — ADDRESS: 53 Hollins

Don't Abbreviate. Write Plainly. Ages should be stated EXACTLY. Physicians should read CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Bks.

E 52860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 52860

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 N. Rose ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert F. Smith

(a) RESIDENCE NO. 37 N. Rose ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Smith

6 DATE OF BIRTH (month, day, and year): Jan 2/1859

7 AGE: Years 71 | Months 0 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. G. S.

(c) Name of employer: U. S. A.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Dora Erlbeck

(Address) 27 N. Bond St

15 Filed JAN 10 1930 19 H. H. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8/30

17 I HEREBY CERTIFY, That I attended deceased from July 90, 19 29, to Jan 8, 19 30;

that I last saw h[e] alive on Jan 8 19 30.

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis (Senile)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility age - chronic Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Mayer, M. D.

1/10 19 30 (Address) 1520 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Jan 11 1930

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 52361

E 52361

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1628 Harford Av 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August T. Heydenreich

(a) RESIDENCE NO. 1628 Harford Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet & Letter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Emil Heydenreich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Miss Ohler

(Address) 1628 Harford Av

15 Filed JAN 10 1930 H. MELVIN JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Jan 8, 1930, that I last saw him alive on Jan 7, 1930 and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Sanguineous Left Limb Chronic Interstitial & Hemaphlegia (Cerebral) Nephritis Had several recurrent attacks Hemaphlegia in last 4 months (duration) 6 yrs. mos. ds. Hemaphlegia + Myocarditis

CONTRIBUTORY (Secondary) Hemaphlegia + Myocarditis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1628 Harford

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R O Carmen, M. D.

1-9, 1930 (Address) 1701 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Jan 11 1930
20 UNDERTAKER Philip Herwig	ADDRESS 2816 Orleans St.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 52862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1291 E 52862

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3801 Hudson St. 26-37 WARD)

2-FULL NAME Mary Theresa Sellman

(a) RESIDENCE NO. 3801 Hudson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 2 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9, 1895

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
34	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coating Machine

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Can 086

(c) Name of employer Continental Can Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Martin Sellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Sellman

(Address) 1342 E. Eager St

15 Filed JAN 10 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Jan 8, 1930.

that I last saw h alive on Jan 7 1930

and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

Chronic nephritis

Marked secondary anemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) L. Schlenger M. D.

, 19 (Address) 303 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL Jan 11 1930

UNDERTAKER Philip Henrig

ADDRESS 2064 Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52863

CERTIFICATE OF DEATH

14 of E 52863

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 3400 Rosedale Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Voegelein Long

(a) RESIDENCE NO. 405 E. 22nd. Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Long

6 DATE OF BIRTH (month, day, and year) January 20th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	67	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Christopher Voegelein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E.B. Wellener

(Address) 3400 Rosedale Ave.

15 Filed JAN 10 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1929, to Jan. 9. 1930

that I last saw her alive on Jan 9. 1930

and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

Right Hemiplegia

(duration) yrs. mos. 41 ds.

CONTRIBUTORY (Secondary) Cerebral arteriosclerosis

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Aisenbrot, M. D.

1-9 1930 (Address) 4012 Pinesc Highlan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 1/11 1930

20 UNDERTAKER Chas F. Wolfe & Son

ADDRESS 1180 Pt Royal Ave

IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

E 52864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-001

E 52364

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3311 Rogers Ave ST. 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annastasia Spitzmagel

(a) RESIDENCE NO. 3311 Rogers ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Spitzmagel

6 DATE OF BIRTH (month, day, and year) Nov 15, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anthony Spitzmagel

(Address) 3311 Rogers Ave

JAN 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to June 10, 1930, that I last saw her alive on June 5, 1930, and that death occurred, on the date stated above, at 5.55 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver (primary)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hodgkin's disease

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Paul O Jamot, M. D.

, 19 (Address) 2516 Penna. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 1/13 1930

20 UNDERTAKER C. Vernon Lemmon

ADDRESS 2010 Penn Ave Weightsville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓

E 52865

1—PLACE OF DEATH So Balto Gen Hosp

REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light St., ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Viola Reusing

(a) RESIDENCE NO. Baton Rouge La ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Reusing

6 DATE OF BIRTH (month, day, and year) 1/22/1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	38	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Pumphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pentfield A.A. Co Md

12 MAIDEN NAME OF MOTHER Julia Fiske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carlingford Ind

14 Informant Mrs John H Reusing

(Address)

15 Filed JAN 10 1930 HAMPSON JONES, M. D. Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/30

17 I HEREBY CERTIFY, That I attended deceased from 1/7, 19 30, to 1/9, 19 30, that I last saw her alive on 1/9, 19 30 and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Mitral Insufficiency

(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? (Over)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) L. J. Resnick M. D.

1/9, 1930 (Address) #3710 Woodbine Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pumphrey Cemetery	Jan 12 1929
20 UNDERTAKER Charles K. Stevens	ADDRESS 1501 E Fort Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 52866

REGISTERED NO. E 52866

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Mt Royal Terrace ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Kemp Bartlett

(a) RESIDENCE NO. 1922 Mt Royal Terrace ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if foreign birth? 74 yrs. 1 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Juliet Reese Bartlett

6 DATE OF BIRTH (month, day, and year): Nov. 17 1855

7 AGE: Years 74 | Months 1 | Days 23 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Treasurer & Sec'y

(b) General nature of industry, business, or establishment in which employed (or employer): Dixon-Bartlett Co.

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Talbott Co. Maryland

PARENTS

10 NAME OF FATHER: Geo. K. Bartlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore Maryland

12 MAIDEN NAME OF MOTHER: Susan Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore Maryland

14 Informant: Miss Elizabeth P. Bartlett
(Address): 1922 Mt Royal Terrace

15 1 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 9, 30.

17 I HEREBY CERTIFY That I attended deceased from Jan 4, 1930, to Jan 9, 1930, that I last saw him alive on Jan 9, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Price C. Clarke, M. D.

1-9, 1930 (Address) 2 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery | DATE OF BURIAL: Jan 11 1930

20 UNDERTAKER: Stewart & Mowen Co | ADDRESS: Balto.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52367

CERTIFICATE OF DEATH

E 52367

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO. 129

CITY OF BALTIMORE: (No. S. 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Johnson

(a) RESIDENCE NO. 603 N. Calhoun St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	58 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 1 9 1930 C. HAMPSON JONES, M. D. Registrar

By ACH

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8-30

17 I HEREBY CERTIFY, That I attended deceased from ~~1-1-30~~ 12-28, 1929, to 1-8-30, 19..., that I last saw him alive on 1-8-30, 19..., and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Chronic

(duration) ... yrs. over 12 mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis: Myocarditis, Chronic (duration) ... yrs. ? mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Lab. Autopsy

(Signed) Warren H. McLean, M. D.

1-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn	1/11/30

20 UNDERTAKER Mrs. Geo. H. Hollan Howard ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 52868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 52868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3204 E. White Ave ST. 21-43 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Jordan

(a) RESIDENCE NO. 3204 E. White ave ST., WARD

(Usual place of abode) Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Jordan

6 DATE OF BIRTH (month, day, and year) June 13 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER Conrad Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Barnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. Maryland

14 Informant Mary W. Jordan (Address) 3204 E. White ave.

15 Filed JAN 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 9, 1930, that I last saw him alive on Jan 7, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? yes Date of Dec 6th 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) Geo. A. Ems, M. D.

1930 (Address) 563 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Co. DATE OF BURIAL Jan. 13 1930

20 UNDERTAKER Frederick Rosati ADDRESS Fullerton

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52869 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

38 E 52869

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (Ward) 3

2-FULL NAME Josephine Orzalaga

(a) RESIDENCE NO. 2347 Eastern Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Leopold Orzazga

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Malkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Feliza Piotrkowski

(Address) 23 W. Hamburg St.

15 Filed ..... PRR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-2 1930 to 1-9 1930, that I last saw her alive on 1-9 1930, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Syphilitic heart disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Autopsy

(Signed) M. Thurnwald M.D.

1/9, 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 1/13 1930

UNDERTAKER Wm F. Falkowski

ADDRESS 1618 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 1 0 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 52870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52870

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 46

CITY OF BALTIMORE: (No. ST., 26 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Fletcher (or Fischetti ?)

(a) RESIDENCE NO. 1401 Highland Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43? or	35 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Chas. Lefler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Regina ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Records of (Address) Balto. City Hospitals

15 Filed JAN 10 1930, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-9-30

17 I HEREBY CERTIFY, That I attended deceased from 12-29-29, 19..., to 1-9-30, 19..., that I last saw her alive on 1-9-30, 19..., and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH* was as follows:

Syphilis of C.N.S.

(duration) ... yrs. over 12 mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix

(duration) ... yrs. over 12 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E. Lab. W.R.

(Signed) Warren H. McClean, M. D.

1-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	1/11/1930
20 UNDERTAKER: John G. Connelly	ADDRESS: Essex Md

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. If death occurred in a hospital or institution, the name of the hospital must be given instead of the street and number. If the deceased was not a resident of the city or town where death occurred, the length of residence should be given for the information of the local registrar. If the place of death is unknown, the coroner should be notified at once. The medical certificate should be completed and signed by the attending physician, if there was one, and he should specify the time in attendance. If there was no physician in attendance, or if he refuses to sign, the coroner must be notified before a certificate is issued. If the cause of death is not definitely known, the coroner must be notified before a certificate is issued. The certificate must be filed with the local registrar before a burial permit is issued.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 ✓ E 52871

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Collington Ave ST., 816 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Jane Lambdin

(a) RESIDENCE NO. 1911 Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	83	0	13 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm D. Lambdin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Bowling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss A. Lambdin

(Address) 1911 Collington Ave

15 N 1 0-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9-30

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Jan 9, 1930,

that I last saw her alive on Jan 9, 1930

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Natural Causes

(over)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Edhamton

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wade, M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 1/11/1930

20 UNDERTAKER Louis Lemmane — ADDRESS 32 S. Broadway

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 52872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52872

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3215 Guilford Ave. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie H. Housten,

(a) RESIDENCE NO. 3215 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Joel Housten,

6 DATE OF BIRTH (month, day, and year) July 10, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	6	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shrewsbury Penna

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Eliza Hedrick,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mrs B. F. Free

(Address) 3215 Guilford Ave

15 Filed JAN 10 1930 C. HUMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 10, 1930, that I last saw h~~er~~ alive on Jan 8, 1930 and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Heart Disease

(Mitral Insufficiency)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jane Baugh, M. D.

Jan 12 1930 (Address) 7 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauderdale Mt Lawn Cem

DATE OF BURIAL JAN 12 1930

20 UNDERTAKER Geo W Settle

ADDRESS 2700 EDMONDSON AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

N 1 0 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52873

CERTIFICATE OF DEATH

127-002 E 52873

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2309 Homewood Ave ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Winfield B Morgan

(a) RESIDENCE NO. 2309 Homewood Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Loretta Cummings

6 DATE OF BIRTH (month, day, and year) 8-11-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment In which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susan McManus

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs E M. Kleff.

(Address) 2309 Homewood Ave

15 Filed 1 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8/30 (1/8/30)

17 I HEREBY CERTIFY, That I attended deceased from 10/9/29, 19, to 1/8/30, 19, that I last saw him alive on 1/8/30, 19, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Hepatitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Gadders, M. D.

1/9/30 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Jan 11 1930

20 UNDERTAKER: Mary W. Wakefield — ADDRESS: 501 E 32nd St

important. See instructions on back of certificates. Every

E 52874

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 5325 Fernhurst Ave, 28-14 WARD)

Registered No. C E 52874

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert S Humphreys

(Residence in Baltimore: No. 5325 Fernhurst Ave

St.: 48 yrs. 9 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: Nov 23 (Month) (Day), 1881 (Year)

7-AGE: 48 yrs. 9 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.? 16

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Grain Inspector
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Joshua Humphreys

11-BIRTHPLACE OF FATHER (State or country): Maryland.

12-MAIDEN NAME OF MOTHER: Sarah S Dove

13-BIRTHPLACE OF MOTHER (State or country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Julia A Humphreys

(Address) 5325 Fernhurst Ave

15 C. HAMPSON JONES, M. D.

~~C. H. JONES, M. D.~~

~~C. H. JONES, M. D.~~ REGISTRAR

JAN 10 1930

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan 9 (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 9 1930, that I saw ~~him~~ her alive on Jan 8 1930, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Myocarditis.

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Irvin Eberach M. D.

Jan 10, 1930 (Address) 715 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Jan 11, 1930

20-UNDERTAKER: John F Denny ADDRESS: 715 Light St

B.-Every item of information should be carefully supplied. AGE should be filled in DAYS if under one month, in MONTHS if under one year. If unknown, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52875

CERTIFICATE OF DEATH.

74-001 E 52875

1-PLACE OF DEATH General German Aged Pfalle Home REGISTERED NO.

City of BALTIMORE (No. N. E. Cor Baltimore & Payson Sts Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliana Vetter

(a) RESIDENCE NO. N. E. Cor Baltimore & Payson Sts Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17. 1834

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	95	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER — Schwerkel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kinkelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Records of German Aged Home

(Address) Balto & Payson Sts

JAN 10 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jan. 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Jan 9th, 1930, that I last saw her alive on Jan 9th, 1930 and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hoff M. D. M. D.

1/10 1930 (Address) 1843 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Jan 11 1930

20 UNDERTAKER Jos B Cook ADDRESS 1003 W Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 SE 52876

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Genl Hospital, 9-46 Ward)

2-FULL NAME Frank A. Sherman

(a) RESIDENCE NO. 503 E 29th St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~formerly WIFE of~~ Julia

6 DATE OF BIRTH (month, day, and year) Sept 22-1899

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
30	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipfitter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town)
(State or country) Newport News Va

PARENTS

10 NAME OF FATHER William J. Sherman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Griggs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Suffolk Va

14 Informant Julia Sherman
(Address) 503 E 29th St

15 Filed ....., 19.... C. HAMPSON JONES M. D. Registrar

NOV 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest & Autopsy, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Contusion of Chest Fell down stairs of Ship

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? Ship Yard

Did an operation precede death? Date of - Jan 8th

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. L. Hellums M. D.

Jan 9 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 11th 1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1806 West Lafayette St., (E. or W.) (D)

2—FULL NAME Rufus E. Holder

(a) RESIDENCE NO. (Usual place of abode) 1806 West Lafayette St., WARD

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annette

6 DATE OF BIRTH (month, day, and year) Sept 14 1846

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	83	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mrs Fannie A. Kendrick

(Address) 1806 W Lafayette

15 Filed JAN 10 1930 C. HAMPSON JONES, M. D. Registrar

By AKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1930

17 I HEREBY CERTIFY, That I attended deceased from January 9 1930 to Jan 10 1930

that I last saw h[illegible] alive on January 9 1930

and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Charles E. Clarke M. D.

(Address) 3214 Pudlum Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte N. C.

DATE OF BURIAL 1/11 1930

20 UNDERTAKER J. McLean Cook

ADDRESS 1217 St Paul

important. See instructions on back of certificates.

JAN 10 1930

Dr. Clark

3214

24-001 E 52877

Forest 6414

E 52878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE (No. 33rd & Calvert ST.) (WARD) 14-70

REGISTERED No. C 88 103 52878

2-FULL NAME George Henry Stickney

(Residence in Baltimore: No. 1612 Park Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 7th, 1851 (Month) (Day) (Year)

7-AGE, 78 yrs. 9 mos. 2 ds. If LESS than 1 day, hrs. or min.:

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Broker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry F Stickney

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Anne Musgrave

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Stickney

(Address) 1612 Park Ave

15- C. HAMPSON JONES, M. D.

Reg. 4854 Resistrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 1 0 1930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9th, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract. C.C. Skull
Run down by auto
while standing in
safety zone await street car

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) C.C. Fract Both Legs

(Duration) yrs. mos. ds.

(Signed) F. D. Kane (Coroner) M. D.

1/10, 1930 (Address) 1939 N. Eden

State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Roland Ave & Club Road

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem

DATE OF BURIAL, Jan 11th, 1930

20-UNDERTAKER Henry W Jenkins Sons & Co

ADDRESS Orchard & Mt Ballard

Spec.—2-29-28—L. F. S.—500 Blks.

John M. Dellosso, Jr. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52879

CERTIFICATE OF DEATH

101-00 E 52879

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4405 Rainfield Ave ST., 27-W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Dellosso, Jr.

(a) RESIDENCE NO. 4405 Rainfield AVE. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 16, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18.	9.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student, Baltimore,

(b) General nature of industry, business, or establishment in which employed (or employer) Business College.

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John M. Dellosso.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Anna C. Edelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John M. Dellosso.
(Address) 4405 Rainfield Ave.

15 Filed JAN 6 1930, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1.9.30.

17 I HEREBY CERTIFY, That I attended deceased from 12.28.29., 19..., to 1.9.30., 19...,
that I last saw him alive on 1.9.30., 19...
and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) - yrs. - mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip B. Towler, M. D.
1.10.30. 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	Jan 13 1930

20 UNDERTAKER A. Edward Evans ADDRESS 38 E. Ford Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Mary E. Hindle

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52880 ✓ 44 E 52880

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 E. Ostend ST. 23-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Hindle.

(a) RESIDENCE NO. 7 E. Ostend ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Hindle, Sr.

6 DATE OF BIRTH (month, day, and year) Feb. 7 - 1872

7 AGE ✓	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57.	11.	1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At. home.

(b) General nature of industry, business, or establishment in which employed (or employer) 0"7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. Spence.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Georgeanna Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Charles W. Hindle, Sr.

(Address) 7 E. Ostend St.

15 Filed 1-10-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1.8.30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to 1.8.30., 19..., that I last saw h.. alive on 1.8.30., 19..., and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Ryelone Carcinoma

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - microscopic

(Signed) O. Kelly B. Towles, M. D.

1.10.30 19 (Address) 1732 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 11, 1930
20 UNDERTAKER	ADDRESS
A. Bernard Evans	25 E. Fort Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52881

CERTIFICATE OF DEATH

90 ✓

1—PLACE OF DEATH

REGISTERED NO. E 52881

CITY OF BALTIMORE: (No. 3443 Ravenwood Avenue ST., 8-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Walston Overman

(a) RESIDENCE NO. 3443 Ravenwood Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Overman

6 DATE OF BIRTH (month, day, and year) 9-13-1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	3	27 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Fritzges

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Frederick Overman Son

(Address) 821 N. Collington Avenue

15 Filed JAN 1 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9-30

17 I HEREBY CERTIFY, That I attended deceased from July 29 to Jan 9, 19 30

that I last saw h[illegible] alive on [illegible] 9 30

and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH was as follows: Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible]

1-11 19 30 (Address) [illegible]

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL 1-13 30

20 UNDERTAKER Albert I. Hilt[illegible] 1606 N. CHESTER ST.

ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

52882 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

124 E 52882

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary T. Nicholson

(a) RESIDENCE NO. 1124 E. 36th St. ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

3a If married, widowed, or divorced (or) WIFE of Mr. Frank Nicholson

6 DATE OF BIRTH (month, day, and year) 12-8-75

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER George Offleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Jehotee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant patient.

(Address)

15 Filed JAN 1 1930 C. JULIAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10, 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26 1929, to Jan. 10, 1930

that I last saw her alive on Jan 10, 1930

and that death occurred, on the date stated above, at 5:05 P.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis.

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 11-27-29.

Was there an autopsy? No.

What test confirmed diagnosis? Resp. Ceased.

(Signed) A. R. Wilkins, M. D.

Jan 13 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Jan 13th 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul st

OF DEATH in plain terms, so that it may be properly classified. Each answer is important. See instructions on back of certificates.

No 1 1930 RRD

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52883

CERTIFICATE OF DEATH

101-001 E 52883

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1221 Chatsham ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Ennin

(a) RESIDENCE NO. 1221 Chatsham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Ennin

6 DATE OF BIRTH (month, day, and year) Unknown 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eliza Humphries

(Address) 1221 Chatsham st

15 Filed 1-1 1930 C. HAMPSON JONES, M. D. Registrar

Past

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-31, 1929, to 1-8, 1930, that I last saw h[illegible] alive on 1-8, 1930 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. m[illegible] 9 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood, Sputum.

(Signed) Williams & Ray Penny M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hill S. C.	Jan. 11 1930
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Eastlander

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52884

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2706 Riggs Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hermann E. Ahrens.

(a) RESIDENCE NO. 2706 Riggs Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Ahrens

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Meyer Seed Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Julius E. Ahrens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Schmenhorst Germany

12 MAIDEN NAME OF MOTHER Elizabeth F. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Birmingham England

14 Informant Mrs Anna M. Ahrens

(Address) 2706 Riggs Ave.

15 Filed JAN 11 1930 19 C. HAMILTON JOHNS, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1924, to Jan 9, 1930, that I last saw h alive on Jan 8, 1930. and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Meyer, M. D.

1/9, 1930 (Address) 1520 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 11 1930
20 UNDERTAKER	ADDRESS
W. Tuckner Sons	North & Pa

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52885

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52885

CERTIFICATE OF DEATH

118

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 9-18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Lamb

(a) RESIDENCE NO. 1104 E. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26 - 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Co.
(b) General nature of industry, business, or establishment in which employed (or employer) Electrician
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. Lamb

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Amanda M Pruett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Joseph H. Lamb
(Address) 804 Fremont Ave

15 Filed (19) C. HARRISON JONES, M. D. Registrar

N 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Surgical shock due to operation for Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

1/11 . 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 11 1930
20 UNDERTAKER	ADDRESS
Geo. F. Ruth	1235 Harford

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52386

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 of 81 E 52386

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 9-18 Ward)

2-FULL NAME Peter Rafferty

(a) RESIDENCE NO. 1835 Aiken St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Rafferty

6 DATE OF BIRTH (month, day, and year) Aug. 15-1853.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
76	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stable Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Buchwald Trans. Co

9 BIRTHPLACE (city or town)
(State or country) Ireland

PARENTS

10 NAME OF FATHER William Rafferty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Conner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Mary C. Rafferty
(Address) 1835 Aiken St.

15 Filed ..... 19 ..... THOMSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to true death (Inquest, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillers, M. D.

1/11 . 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemy.

DATE OF BURIAL Jun 14 1930

20 UNDERTAKER Geo. J. Roth

ADDRESS 1735 Harford Ave

JAN 11 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52887

CERTIFICATE OF DEATH

161-01 E 52887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 535 N. Central Ave St., 5-6 Ward)

2-FULL NAME Cora Lee Jones

(a) RESIDENCE NO. 535 N. Central St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 20 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			20 19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Harvey Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Lillian Johns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Lillian Johns Jones
(Address) 535 N Central Ave

15 Filed 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said injury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature

(about 7 months gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. H. Callan, M. D.

1/10, 1930 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury Cemetery

DATE OF BURIAL Jan 11 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Arlington

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 11 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 52888

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52888

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital — REGISTERED NO. 72-20

CITY OF BALTIMORE: (No. ..... ST. ..... WARD .....)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Shaffer (Schaffle)

(a) RESIDENCE NO. 312 Emory St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 17/1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt Ironer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Richard Schaffle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie A. Thielmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Annie A. Schaffle

(Address) 150 W. Lexington

15 Filed ..... 19..... Registrar

JAN 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10th, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1930, to January 10th, 1930

that I last saw h[illegible] alive on January 6th, 1930

and that death occurred, on the date stated above, at 6 10 A.m.

The CAUSE OF DEATH* was as follows:

Influenza

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

..... (duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis P. Gundry, M. D.

Jan 11th, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem — DATE OF BURIAL Jan 13 1930

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 ✓ E 52889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 12-50 Ward)

2-FULL NAME Robt F. Jackson

(a) RESIDENCE NO. 2408 Brentwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 22-1908

7 AGE: Years 21 | Months 11 | Days 14 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chemist & Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) 068
(c) Name of employer

9 BIRTHPLACE (city or town) Butte Mont.
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Jackson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Estelle Hoskins

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Wm H. Jackson Father
(Address) 2408 Brentwood St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry), and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

Accident

(duration) ..... yrs. ..... mos. 3 days

CONTRIBUTORY (Secondary) Ind degree burns due to testing chemicals

(duration) ..... yrs. 3 mos. ? ds.

18 Where was disease contracted if not at place of death? 2407 Fremont Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Hollins, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1/11 19 30
20 UNDERTAKER	ADDRESS
Samuel J Kennedy	578 N Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 11 1930

ARB

Spec.—1-12-23—M&T—500 Bks.

E 52890 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 VÉ 52890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1641 N Wolfe ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hardester

(a) RESIDENCE No. 1641 N Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Hardester

6 DATE OF BIRTH (month, day, and year): 1842

7 AGE: Years: 88 Yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Samuel Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): C. C. Hardester (Son)

15 Filed 1-11-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-9-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 er, 1929, to Jan 9, 1930, that I last saw h alive on 1-9, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos 11 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) D. Hamilton Jones, M. D.

1/11, 1930 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 1/13/30

UNDERTAKER: Frederick R. Cole

ADDRESS: 1616 N Broadway Balto.

CAUSES OF DEATH must be plainly written, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52091

CERTIFICATE OF DEATH.

90 ✓E 52091

REGISTERED NO. 13-52

1-PLACE OF DEATH

City of BALTIMORE: (No. 3448 Keswick Road Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carson E. Ruby

(a) RESIDENCE NO. 3448 Keswick Road. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ ✓

6 DATE OF BIRTH (month, day, and year) May 21, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER George W. Ruby

11 BIRTHPLACE OF FATHER (city or town) md.

(State or country)

12 MAIDEN NAME OF MOTHER Uriah W. Jett

13 BIRTHPLACE OF MOTHER (city or town) md.

(State or country)

14 Informant Uriah W. Ruby

(Address) 3448 Keswick Road

JAN 11 1930

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John J. Weisberg, M. D.
(Coroner)

1/10 1930 (Address) 3672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial Jan 11, 1930

20 UNDERTAKER Chenoweth Son ADDRESS 2415 Chestnut

BE SURE to answer every question. Use ditto marks only when necessary. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 52392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 E 52892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3143 Dillon ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Daniel Malecki

(a) RESIDENCE No. 3143 Dillon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 14-1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Malecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Julia Lisicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Michal Malecki

(Address) 3143 Dillon St

15 Filed 1930, 19 C. HAMSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 10, 1930, that I last saw h[illegible] alive on Jan. 10, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Maraasmus

(duration) yrs. 2 mos

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Bilbro, M. D.

1/10, 1930. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Jan 11 1930 DATE OF BURIAL

20 UNDERTAKER D. W. Rozenski ADDRESS 1930 Eastern Ave

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52693

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Shannon

(a) RESIDENCE NO. 339 E-Lombard St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorrrd
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/15/1874

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
55	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Soldier
(b) General nature of industry, business, or establishment in whirh employed (or employer) U.S. army
(c) Name of employer

9 BIRTHPLACE (city or town) Lawrence
(State or rountry) Ohio

PARENTS

10 NAME OF FATHER Albert Shannon

11 BIRTHPLACE OF FATHER (rity or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (rity or town)
(State or country) Ohio

14 Informant Dwight Fulton
(Address) 339 Lombard St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said drreasrd came to his death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:
Fall. (Cause unknown)
Fracture of Skull

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. 5 da.

(duration) yrs. mos. 1 da.

18 Where was disease contrarted If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Post Mo.

(Signed) Geo Glades M. D.

. 19 (Address) 370 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Aecidental, Suieidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Akron Ohio.

DATE OF BURIAL 1/11/30

20 UNDERTAKER George D. Ruth

ADDRESS 1353 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 1 1930

BALTIMORE JUN 2

Reg.

1009

Spec.–7-17-26—A Co.—200 Bks.

E 52894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52894

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. Asthma McColum 2233 Ward

2-FULL NAME Md. Gen. Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1707 S. Charles St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Aug. 22-1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer B. & O.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O.

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md

PARENTS

10 NAME OF FATHER Martin Calson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Julia Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md.

14 Informant Hospital Records (Address)

15 Filed JAN 11 1930 C. HANSON JONES, Registrar By 1107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 30 to Jan 10, 19 30

that I last saw h[illegible] alive on Jan 10, 19 30

and that death occurred, on the date stated above, at 11:07 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Embolism & Thrombosis Femoral artery (Left) & gangrene of leg.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible] John's Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial 1/13 1930

20 UNDERTAKER L. F. McCully — ADDRESS 130 E. Fort

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 52895

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick Riley

(a) RESIDENCE NO. 1410 Eastern Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Felix Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed 1 1 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6-30

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1927, to 1-6, 1930, that I last saw h[illegible] alive on 1-6, 1930 and that death occurred, on the date stated above, at 11 P — m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

1-8, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 1/11 1930

20 UNDERTAKER John J. Fahey Son — ADDRESS 1318 Light

IMPORTANT. See instructions on back of certificates. Be sure that all items are properly checked. Exact statement of OCCUPATION is very important.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52896

CERTIFICATE OF DEATH

56 E 52896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1131 W Lombard St., 18-24 Ward)

2-FULL NAME Raymond J Mulligan

(a) RESIDENCE NO. 1131 W Lombard St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred # yrs. # mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 13th 1929

7 AGE Years	Months	Days 29 28.	IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none old
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Lewis Mulligan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Barger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mr Lewis Mulligan
(Address) 1131 W Lombard St

15 Filed JAN 1 1930 C. HAMILTON JONES, M. D. Registrar
By MARIE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10th 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Malnutrition
Cachexia

(duration) yrs. Last ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Hospital Records
What test confirmed diagnosis?
(Signed) H. C. Wade, M. D.
, 19 (Address) 1 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 11th 1930
20 UNDERTAKER John J Cowan & Son	ADDRESS 901 Hollins

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 52397

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52397

CERTIFICATE OF DEATH

X 129

1-PLACE OF DEATH

City of Baltimore: (No. 1412 Argyle St., 8-14-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ambrose F. Gough

(a) RESIDENCE NO. 1412 Argyle St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy J.

6 DATE OF BIRTH (month, day, and year) July 25-1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 186
(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co
(State or country) Md

PARENTS

10 NAME OF FATHER Fred Gough

11 BIRTHPLACE OF FATHER (city or town) St Marys Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary P. Campbell

13 BIRTHPLACE OF MOTHER (city or town) St Marys
(State or country) Co Md

14 Informant Lucy Gough
(Address) 1412 Argyle

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Marys Co Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wm. Leonard M. D.
Jan 17 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys [illegible] DATE OF BURIAL 1/12 1930

20 UNDERTAKER Daniel Easton ADDRESS 916 O'Sullivan

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 2 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 52398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52398 ✓ E 52398 X 93

1—PLACE OF DEATH

REGISTERED NO. 30

CITY OF BALTIMORE: (No. University Hospital) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles R. Amos

(a) RESIDENCE NO. West Friendship ST., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah Amos.

6 DATE OF BIRTH (month, day, and year) Sept 22, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	67	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oliver C. Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Theresa Favor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Charles Amos

(Address) West Friendship Md

15 Filed JAN 12 1930 WILLIAM P. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 - 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 12, 1930

that I last saw h... alive on Jan 12, 1930

and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Varicose Hemmorrhage

Left Leg.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Shock

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W Steb- M. D.

Jan 12, 1930 (Address) West Friendship

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Cem.

DATE OF BURIAL Jan. 14 1930

UNDERTAKER Easton Sons

ADDRESS Ellicott City

OF DEATH in Birth forms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 | E 52899

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. 7-30 Ward

2-FULL NAME Lida Adams

(a) RESIDENCE NO. 526 W Lee St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Mr Armstrong

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margret Williams

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Margret Armstrong
(Address) 526 W. Lee Street

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cut LB

(duration) 7 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ex Exhaustion

(duration) ..... yrs. ..... mos. / ds.

18 Where was disease contracted if not at place of death?

Did operation precede death? ..... Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Inquiry

(Signed) W. E. Gladden, M. D.

19 (Address) 1230 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemtry

DATE OF BURIAL 1/12 1930

20 UNDERTAKER Walter B. Briggs

ADDRESS 139 Mt Auburn st

ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 12 1930

Spec.—8-16-29—L. F. S.—100 Bks.

Frederick T. Mitchell

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 74-001 V

E 52900

E 52900

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. F. G. Mitchell

(a) RESIDENCE NO. Glencoe ST. Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Fannie R Mitchell

6 DATE OF BIRTH (month, day, and year) Aug 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
73	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor of Medicine

(b) General nature of industry, business, or establishment in which employed (or employer) 654

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md.

PARENTS

10 NAME OF FATHER Dr. F. G. Mitchell

11 BIRTHPLACE OF FATHER (city or town) Hagerstown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Elizabeth Yost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Maryland

14 Informant Mrs. F. G. Mitchell

(Address) Glencoe, Md.

15 Filed JAN 12 1930 Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Jan 11, 1930, that I last saw him alive on Jan. 11, 1930 and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) Eldred Robertson, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glencoe, Maryland — DATE OF BURIAL Jan. 14 1930

20 UNDERTAKER Wm. C. Brodbeck Jr — ADDRESS Sparks, Md.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52901

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1618 ~~Harlem~~ Division ST. 16-27 WARD) 101-08

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucille Jones

(a) RESIDENCE NO. 1618 Harlem ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23, 1929

7 AGE	Years	Months	Days 16	If LESS than 1 day, hrs. or min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jentry McDonald.

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margaret Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Margaret Jones

(Address) 1618 Harlem ave.

15 Filed JAN 12 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 9, 1930, that I last saw her alive on Jan 9, 1930 and that death occurred, on the date stated above, at 4.45 ~~P~~ m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M Stein, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 1/12 1930

20 UNDERTAKER John J Raley Sons

ADDRESS 1318 Light St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52902

CERTIFICATE OF DEATH

90

E 52902

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3304 Auchentoroly Terrace ST. 57 WARD)

2—FULL NAME Ethel Ridgley Bradenbaugh

(a) RESIDENCE NO. 3304 Auchentoroly Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 45 yrs. 8 mos. 27 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: C. Lee Bradenbaugh

6 DATE OF BIRTH (month, day, and year): April 14 1884

7 AGE: Years 45 | Months 8 | Days 26 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Libertytown Maryland.

PARENTS

10 NAME OF FATHER: Jos. E. Hinkelfor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Libertytown Maryland

12 MAIDEN NAME OF MOTHER: Fannie C. Gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Mr. C. Lee Bradenbaugh Husband

(Address) 3304 Auchentoroly Ter.

15 FILED JAN 12 1930, 19... H. LEVERTON JONES, M. D. Registrar

JAN 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Jany 10, 1930, that I last saw h e alive on Jan 10, 1930 and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis - Hyper Tension.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. Whyte M. D.

1/11, 1930 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Libertytown Funeral Co. Md. DATE OF BURIAL: Jan 13 1930.

20 UNDERTAKER: Stewart & Mercer Co. ADDRESS: Balto.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52903

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 44-27 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alverta Briscoe

(a) RESIDENCE NO. 520 Gilmore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 14? yrs. ?mos. ?ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Briscoe

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 2 1930 C. Hampson JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9-30

17 I HEREBY CERTIFY, That I attended deceased from 1-7-30, 19..., to 1-9-30, 19..., that I last saw h.er alive on 1-9-30, 19..., and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) about ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: P.E: Lab

(Signed) Marion W. McLean, M. D.

1-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Jan 12, 30

20 UNDERTAKER Sam'l W. Chase Sons

ADDRESS 1400 Mosher

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52904

CERTIFICATE OF DEATH

43

E 52904

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 N. Appleton ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Shapiro

(a) RESIDENCE NO. 1515 N. Appleton ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE Hyman Shapiro

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Clarence Shapiro
(Address) 1515 N. Appleton St

15 Filed JAN 12 1930, 19..., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11/30

17

I HEREBY CERTIFY, That I attended deceased from January 1, 1928, to 1-10, 1930; that I last saw h.. alive on 1-10, 1930 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Right Breast (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Not necessary

(Signed) Myer A. Weinstein, M. D.

1/11, 1936 (Address) 1724 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 1/12 1930

20 UNDERTAKER Jack Levin 1439 Eutaw St — ADDRESS

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 52905
REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (Monument & Rutland) 16-37 WARD)

2-FULL NAME Leona Funderburke

(a) RESIDENCE NO. 3736 Eastern ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ben Funderburke

6 DATE OF BIRTH (month, day, and year) June 28-1904

7 AGE — Years: 25 Months: 6 Days: 17 If LESS than 1 day, hrs. or min.: 16

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Louis Poganek
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: Bell Samuels
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Louis Poganek
(Address): 3800 Eastern ave

15 Filed JAN 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1930

17
I HEREBY CERTIFY, That I attended deceased from Dec. 29 1929 to Jan. 10 1930
that I last saw her alive on Jan. 10 1930
and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:
Chronic cardia valvular disease (mitral stenosis & insufficiency)
Subacute bacterial endocarditis
Multiple emboli
(duration) yrs. 3 mo (?) ds.
CONTRIBUTORY (Secondary) Cardiac failure & bronchopneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? lab. & physical
(Signed) Benjamin Cohen M. D.
1/10 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel
DATE OF BURIAL: 1/12 1930
UNDERTAKER: Joch & Leuis
ADDRESS: 1439 E Balt st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 52906

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 52906

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1232 Division ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Alexander Gross

(a) RESIDENCE NO. 1232 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Emma Gross

6 DATE OF BIRTH (month, day, and year) July 19, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 46

(b) General nature of industry, business, or establishment in which employed (or employer) Chemical Co

(c) Name of employer Mutual Chem. Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Mack Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Money

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Gross

(Address) 1232 Division

15 Filed JAN 12 1930, C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10/30

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 10, 1930

that I last saw him alive on Jan 10, 1930

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinomata (peritoneal)

(duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. M. Card M. D.

1/11, 1930 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leland Creek Md DATE OF BURIAL Jan 13 1930

20 UNDERTAKER Samuel H. Greenberg ADDRESS 527 E Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 52907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-001

E 52907

REGISTERED NO. 10-14

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Fremont Ave. B. C. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Millard R. Langley

(a) RESIDENCE NO. 1012 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 7-1898

7 AGE: Years 31 | Months 6 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Walter Langley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va

12 MAIDEN NAME OF MOTHER: Carrie Lackey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Walter Langley

(Address) 1012 N. Eden St

15 JAN 12 1930 H. C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 9-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 9, 1930, that I last saw h— alive on Jan 9, 1930 and that death occurred, on the date stated above, at 6-20 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) [illegible] M. D.

, 19 (Address) 2329 Fairfax Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 1/12/30

20 UNDERTAKER: Samuel I. Hendrix

ADDRESS 518 Eddy

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hosp.

REGISTERED NO. 126 E 52908

CITY OF BALTIMORE: (No. 26-37 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stephen Norris

(a) RESIDENCE NO. 3711 Gough St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) ~~Nov 23 1885~~ Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44 ?	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Md.

PARENTS

10 NAME OF FATHER Warren Norris

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Hopkins

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of Mrs L. Brim 822 S Eaton (Address) B.C.H.

15 Filed JAN 2 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-30

17 I HEREBY CERTIFY, That I attended deceased from 1-9-30, 19..., to 1-10-30 19..., that I last saw him alive on 1-10-30, 19..., and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis purulent

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E. Lab. Autopsy

(Signed) Marvin M. McLean, M. D.

1-11, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tabernacle Cem. Harford Co.

DATE OF BURIAL Jan 13 1930

20 UNDERTAKER John Merick

ADDRESS 2008 Orleans

important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52909

CERTIFICATE OF DEATH

118-002
E 52909
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Gus Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter L. ~~Bautrick~~ Botorek

(a) RESIDENCE NO. 309 S Potomac St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mfe

6 DATE OF BIRTH (month, day, and year): 8-29-1889

7 AGE — Years: 40 Months: 4 Days: 13 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Emanuel Botorek

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie ?

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): Hosp. Records

Filed JAN 12 1930 C. HAMPSON JONES, M. D. Registrar

For RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 1-11-1930

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to 1-11-1930 19.....

that I last saw him alive on 1-11-1930 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

a. Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Paralysis Illness

(duration) ..... yrs. ..... mos. 16 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1-8-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Osmundsen, M. D.

(Address) 1530 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem

Date of Burial: Jan 14 1930

UNDERTAKER: John Ulrich

ADDRESS: 2008 Eutaw St

(If not buried, cremated or removed within 24 hours after death, the permit must be issued by the Registrar.)

(Physician should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—2-29-28—L. F. S.—500 Bks.

E 52910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001 E 52910

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 704 S. Rose ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edmund Wisniewski Jr.

(a) RESIDENCE NO. 704 S. Rose ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 7th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edmund Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie Karey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Edmund Wisniewski

(Address) 704 S. Rose St.

15 Filed JAN 12 1930, 19 C. HAMPSON JONES, Registrar

Wat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11/30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan. 11, 1930

that I last saw h alive on Jan 11, 1930

and that death occurred, on the date stated above, at 9:12 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edmund Wisniewski, M. D.

1/11, 1930 (Address) 7584 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Jan 13 1930
20 UNDERTAKER	ADDRESS
Stephen J. Frakowski	1000 S. Kenwood Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52911

CERTIFICATE OF DEATH

168

E 52911

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4114 Fernhill Ave 15-63 Ward)

2-FULL NAME Henry A Ulrich

(a) RESIDENCE NO. 4114 Fernhill St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria

6 DATE OF BIRTH (month, day, and year) Mar 14-1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	55	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Route
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Ulrich

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Frances Ulrich
(Address) 4114 Fernhill Ave

15 Filed JAN 2 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - by hanging

Strangulation

(duration) yrs. mos. ds. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquest

(Signed) H. Beach Carter, M. D.

Jan 11 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Jan 13 1930
20 UNDERTAKER	ADDRESS
Jacob Seyfer	1600 W North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Mks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52912

CERTIFICATE OF DEATH.

100-001 ✓ E 52912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2850 Woodbrook St. 12-54 WARD)

2-FULL NAME John E. Price

(a) RESIDENCE NO. 2850 Woodbrook ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna P. Price

6 DATE OF BIRTH (month, day, and year) Dec 7 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) B. T. & S. Co

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Chestnut Ridge Baltimore Co Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Information Carroll Price

(Address) 2850 Woodbrook Ave

JAN 12 1930 H. A. JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 11, 1930, that I last saw her alive on Jan 11, 1930, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 4 ds.,

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lemmon M. D.

1/11, 1930 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Slaters Church	Jan 14 1930
20 UNDERTAKER	ADDRESS
Greath Sefer	1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 E 52913

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna G. Geckle

(a) RESIDENCE NO. 1140 Montpelier St ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced (or) WIFE of John E. Geckle

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	Approximately		

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER James H. Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary Scully

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant John E. Geckle
(Address) 1140 Montpelier St

15 Filed JAN 12 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930 to Jan 11, 1930, that I last saw her alive on Jan 11, 1930 and that death occurred, on the date stated above, at 1 52 a m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis (Meningococcic)

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Ruptured Ovarian Cyst + peritonitis

Organism unknown (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Lumbar puncture + Autopsy

What test confirmed diagnosis?

(Signed) Myron G. Tull, M. D.

1/12, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 13 1930
20 UNDERTAKER	ADDRESS
Henry Hoeck Son, Inc.	1301 E Eager St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

52914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. E 52914

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1107 Hillen St., 5-8 Ward)

2-FULL NAME Mary E. Koenig

(a) RESIDENCE NO. 1107 Hillen St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Koenig

6 DATE OF BIRTH (month, day, and year) Feb 13/1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	79	11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Christian Borman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant William Koenig
(Address) 1107 Hillen St.

15 Filed ..... 19.... [illegible] JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Collins, M. D.

1/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan. 13 1930

20 UNDERTAKER Henry Troeck Sons, Inc. — ADDRESS 130 E Eager

DON'T should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

652915 ✓ 652915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 15-65 29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4104 Belleau ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ophelia A Keyser

(a) RESIDENCE NO. 4104 Belleau ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herman Keyser

6 DATE OF BIRTH (month, day, and year) Sept 16 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thomas Betton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ella A Bucher

(Address) 4104 Belleau

15 Filed JAN 12 1930 By H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 30

17 I HEREBY CERTIFY, That I attended deceased from 10/1/29, 19, to 1/10, 1930 that I last saw her alive on 1/9, 19 30 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C Hutzenbuehler, M. D.

1/11, 1930 (Address) 579 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Ridge Cem	Jan 13 1930
20 UNDERTAKER	ADDRESS
W M Coulson	2230 N Mt

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

ES 2916 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ES 2916.

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 253 London Ave St.) (WARD) 20-7L

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C Geddes

(a) RESIDENCE NO. 253 London Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Katherine

6 DATE OF BIRTH (month, day, and year) May 3rd 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sexton - (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Church 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Geddes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Conley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Margaret Ellis

(Address) 253 London Ave

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1929 to Jan 11, 1930, that I last saw h[illegible] alive on Jan 11, 1930 and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial decompensation

Nephritis Chronic

Parenchymatous

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Eliot W. Johnson, M. D.

, 19 (Address) 3326 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Jan 13th 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

Spec.—8-16-29—L. F. S.—100 Bks E-52917

232834 E 52917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52917

REGISTERED NO. 59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST. (WARD) 27 4T

2—FULL NAME Gretchen Lee Wells

(a) RESIDENCE NO. 3114 Brookshire Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-7-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Howard L Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna De Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 13 1930 19 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-12-30

17

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Jan 12, 1930, that I last saw her alive on Jan 12, 1930, and that death occurred, on the date stated above, at 1 15 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) R. O. G. Warren, M. D.

1/12, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 1/13 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52918

E 529[illegible]8

Humy Garrell

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E. 52918

84

E 529[illegible]8

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1609 E. Chase ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Humy Gorrell

(a) RESIDENCE NO. 1609 E Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Gorrell.

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 54 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jesse Heaton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Baltimore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs George Hoge

(Address): 1803 Edgewood St

15 Filed JAN 13 1930 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8th, 1930, to Jan. 12th, 1930, that I last saw h. alive on January 11th, 1930 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

Jan. 13 1930 (Address) 1223 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marks. Cecil Co. Md

DATE OF BURIAL: 1/13 1930

20 UNDERTAKER: [illegible] Cook

ADDRESS: 1217 E Pond St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52919 — E 52919

1—PLACE OF DEATH Union Memorial Hosp. — REGISTERED NO.

CITY OF BALTIMORE: (No. 33d & Calvert St. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Henry Uhrig.

(a) RESIDENCE NO. 2907 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of, (or) ~~WIFE of~~ Unknown

6 DATE OF BIRTH (month, day, and year) May 5, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	81	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Uhrig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Wilhelmina Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Anna Uhrig
(Address) 2411 N. Franklin St.

15 Filed ..., 19... C. HAMPTON JONES, M. D.
By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Jun 11, 1930, that I last saw ~~him~~ alive on Jun. 11, 1930 and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pleural effusion,

Left (duration) — yrs. — mos. 23 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Prone (2) Thoracentesis

(Signed) W. H. Lafferd Jr., M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan. 14, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Place
Weldon B. Mitchell

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52920

CERTIFICATE OF DEATH

29 E 52920

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Bolton St. ST. 14-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Moore Henrix

(a) RESIDENCE NO. 1414 Bolton St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 4 mos. 29 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas J. Henrix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bethia Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Wm. H. Jackson

(Address) 4700 Springdale Ave.

15 Filed JAN 13 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Jan 11, 1930, that I last saw h[er] alive on Jan 10, 1930 and that death occurred, on the date stated above, at 1120 m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis,

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Helen M. Evans, M. D.

Jan 12, 1930 (Address) 612 N 46

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy.

DATE OF BURIAL: Jan. 13, 1930

20 UNDERTAKER: John C. Mitchell & Son

ADDRESS: 1900 Eutaw Pl

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52921

CERTIFICATE OF DEATH

31 ✓

E 52921

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1122 S Paca ST. 2124 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A Knapp.

(a) RESIDENCE NO. 1122 S Paca. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Singer

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Benj Franklin Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Easter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Katherine Knapp

(Address) 1122 S Paca St

15 Filed JAN 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 12 - 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1929, to Jan. 10, 1930, that I last saw him alive on Jan 10, 1930 and that death occurred, on the date stated above, at 8 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Young, M. D.

Jan 13. 1930 (Address) 1122 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 1-14 1930

20 UNDERTAKER Bernard C. Harle

ADDRESS 1000 S Paca St

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52922

CERTIFICATE OF DEATH.

199 E 52922

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto Gral Hospital St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J Shipley

(a) RESIDENCE NO. 1910 N Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nano B Shipley

6 DATE OF BIRTH (month, day, and year) DEC 7th 1896

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
33	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wallace S. Shipley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen A Reid

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Nano B Shipley

(Address) 1910 N Lombard St

C. HAMPSON JONES, M. D.

15 Filed 1 3 1930 19 By Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

18 CAUSE OF DEATH* was as follows: Fract. Skull. Fract Rheare. Fract Left femur — car he was driving ran off of road & car coming in opposite direction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner) M. D.

1-12 1930 (Address) 1939 N. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Pauls Valley Okla

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loraine Cemetery 1-14 1930

20 UNDERTAKER — ADDRESS

Bernard C Harle 1000 S Paca St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 52923

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 N. Chapel St. 6-9 WARD)

2—FULL NAME Albert Harrison

(a) RESIDENCE NO. 115 N Chapel ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Steve Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Woolford

(Address) 115 N Chapel St

15 Filed 1-13, 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10/30

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Jan 10, 1930, that I last saw him alive on Jan 9, 1930 and that death occurred, on the date stated above, at 10 05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Parotid with extension into Ext. Jug. (left)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemmorhage from Ext. Jug.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R F Young, M. D.

1/10, 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 1-13 1930

20 UNDERTAKER Byron Wright

ADDRESS 1218 McCulloh St

important. See instructions on back of certificates.

Spec.—2-29-28—L. P. B.—500 Blks.

E 52924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 52924

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST. 10-14 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Duke Stewart

(a) RESIDENCE NO. 929 Harford Ave. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? — yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Steward

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) ? 045

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Geo. Stewart

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Sedonia Lee

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed JAN 3 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9-30

17 I HEREBY CERTIFY, That I attended deceased from 4-30, 19 29, to 1-9, 19 30, that I last saw h.was alive on 1-9, 19 30 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic diffuse

(duration) over 9 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) over 8 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Histological Wassermann Autopsy

(Signed) Warren H. McLean, M. D.

1-12, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 1-14 1930

20 UNDERTAKER Byron & Wright 1218 Madison Ave

ADDRESS

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52925 E 52925

E 52928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

183 E 52928

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq Hosp 18 N St., Ward)

2-FULL NAME William Brooks

(a) RESIDENCE NO. 821 Little Ct St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, ~~Married~~, ~~Widowed~~ or ~~Divorced~~ (write the word)
male	colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1916

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	13	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work school-boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Brooks

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Chase

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country) Md

14 Informant Mary Brooks
(Address) 821 Pebble Court

15 Filed ..... 19..... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound of Neck
(Recovered) Cause Not known

(duration) ..... yrs. ..... mos. 16 da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Gladden, M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Jan. 13, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 E Monument St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 13 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 52926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 52926

REGISTERED NO. 20-21

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. # 109 N. Payson ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME J. Edward Feinour

(a) RESIDENCE NO. # 109 N. Payson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 4 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence E. Feinour

6 DATE OF BIRTH (month, day, and year) Sept 1, 1892.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Product Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles W. Feinour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary C. Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Florence E. Feinour

(Address) # 109 N. Payson St.

15 Filed JAN 13 1930, 19 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11th, 1930

17 I HEREBY CERTIFY, That I attended deceased from [illegible]5, 1930, to Jan 10, 1930, that I last saw him alive on Jan 10, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lobar ? pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Examinations

(Signed) [signature] M. D.

1/13, 1930 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 14, 1930
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52927.

CERTIFICATE OF DEATH

1929 ✓ E 52927

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 2816 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elise Muchlmeyer (Sister M Louise)

(a) RESIDENCE NO. Melbourne Ky ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. ds. 14 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec. 6. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Convent.

9 BIRTHPLACE (city or town) (State or country) Alsace France

PARENTS

10 NAME OF FATHER Alois Muchlmeyer

11 BIRTHPLACE OF FATHER (city or town) Alsace (State or country) France

12 MAIDEN NAME OF MOTHER Margaret Engel

13 BIRTHPLACE OF MOTHER (city or town) Alsace (State or country) France

14 Informant Mt Hope Retreat

(Address) Mt Hope Retreat

15 JAN 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Jan 12, 1930, that I last saw her alive on Jan 11, 1930, and that death occurred, on the date stated above, at 12.30 noon m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis (Septicemia)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Depression Psychosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Physical

(Signed) Julian P. Hill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Covington Kentucky	Jan 13, 30
UNDERTAKER Chas P. Ware & Son	ADDRESS 18 W 4th Royal Ave

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

52928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 B 52028

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eliza Sts 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Johnson

(a) RESIDENCE No. 517 N. Central Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Pearl Johnson

6 DATE OF BIRTH (month, day, and year): [illegible] 1888

7 AGE — Years: 32 — Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): York, S. C.

PARENTS

10 NAME OF FATHER: John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Hettie Whitesides

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Pearl Johnson

(Address): 517 N. Central Ave

15 Filed JAN 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-10 1930

17

I HEREBY CERTIFY, That I attended deceased from 10-15, 1929, to 1-10, 1930,

that I last saw him alive on 1-10-, 1930,

and that death occurred, on the date stated above, at 5-10 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric ulcer.
Subdiaphragmatic abscess
Duodenal fistula

(duration) yrs. 2 mos 25 ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home 10-17-29

Did an operation precede death? yes Date of 11-27-29

Was there an autopsy? no 1-3-30

What test confirmed diagnosis? Operation

(Signed) N B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Blue Island, S. C.

DATE OF BURIAL: Jan. 13, 1930

UNDERTAKER: Mrs. R. L. Elliott

ADDRESS: Neo Eastland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 52929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 52929

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 E. Eager ST. 10-14 WARD)

2-FULL NAME Mary E. Ward

(a) RESIDENCE NO. 814 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov. 6. 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19 yrs.	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John J. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary B. Lump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Mrs Mary B. Ward

(Address) 814 Eager St

JAN 13 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12. 1930

17

I HEREBY CERTIFY, That I attended deceased from SEP 1 - 1929, to JAN 11 1930, that I last saw her alive on JAN 11 1930, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia resulting from broken compensation of heart

(duration) X yrs. X mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Rheumatic (duration) X yrs. 4 mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Otto F. Dinker, M. D.

JAN 15 1930 (Address) 926 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 14. 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 942 E. Eager St.

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52930

CERTIFICATE OF DEATH

52916

100-001

E 52930

1—PLACE OF DEATH University Hospital

REGISTERED NO. E 52930

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Greene St. 4-30 WARD)

2—FULL NAME Milburn Whitt

(a) RESIDENCE NO. Princess Anne Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant University Hospital

(Address) Baltimore

15 Filed JAN 3 1930 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11/30

17

I HEREBY CERTIFY, That I attended deceased from 12/22, 1929, to 1/11, 1930, that I last saw him alive on 1/11, 1930 and that death occurred, on the date stated above, at 11:40 P.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(Bronchial (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Picture

(Signed) Lewis P. Yunday, M. D.

June 7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Princess Anne — DATE OF BURIAL Jan 14 1930

20 UNDERTAKER E O Watson — ADDRESS Princess Anne

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23272 E 52931

CERTIFICATE OF DEATH

E 52931

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Porter Juliel

(a) RESIDENCE NO. Pittsburgh Pa ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Bess

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work auto-mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) unknown 086

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Silas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Sara Nicholson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 13 1930, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12-30

17 I HEREBY CERTIFY, That I attended deceased from 1-4-, 1930, to 1-12-, 1930, that I last saw h alive on 1-12-, 1930 and that death occurred, on the date stated above, at 5 20 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Dural Endothelioma (Benign)

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 10 yrs. mos. ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Pittsburg Pa.

Did an operation precede death? Yes Date of Jan 9, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence B Gardner M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Confluence Pa DATE OF BURIAL 1/13 1930

20 UNDERTAKER Jos Ahern ADDRESS 211 N Bdway

important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52962

E 52932

1—PLACE OF DEATH

REGISTERED NO. 2638

CITY OF BALTIMORE: (No. 1231 N. Eastend St ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John G. Zeller

(a) RESIDENCE NO. 1231 N. Eastend St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Zeller

6 DATE OF BIRTH (month, day, and year) October 4, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Pennsylvania R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Zeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Frances Zeller

(Address) 1231 N. Eastend St

15 Filed JAN 13 1930 G. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 10, 1930, that I last saw him alive on Jan 9, 1930 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) 3 yrs. mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What was confirmed diagnosis? Dy G

(Signed) G C Glades, M. D.

(Address) 1431 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Cem DATE OF BURIAL Jan 13 1930

20 UNDERTAKER Handell Hollopeter ADDRESS 2008 Eden

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 52933

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Aisquith St. 10-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clemens Athmann

(a) RESIDENCE NO. 1000 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth 58 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of this Dec'd Agnes L. Athmann

6 DATE OF BIRTH (month, day, and year) Feb. 28 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Manufacture.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry A. Athmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Miss. Katherine M. Athmann (Address) 1000 Aisquith St

15 Filed JAN 13 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 12 1930

17 I HEREBY CERTIFY, That I attended deceased from January 19 29, to Jan 12, 1930, that I last saw h~~im~~ alive on Jan 10, 1930 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

Cerebral Hemorrhage (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Previous history

(Signed) Thomas J Corner, M. D.

, 19 (Address) 1001 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Jan. 15 1930

UNDERTAKER Henry Storck Sons, Inc. — ADDRESS 1301 E Eager

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-004

REGISTERED NO. E 52934

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Somerset ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sabina Rausch

(a) RESIDENCE NO. 1123 Somerset ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Rausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Reifert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Barbara Rausch

(Address) 1123 Somerset St

15 Filed JAN 13 1930 19 H. [illegible] Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 11 1930

17 I HEREBY CERTIFY That I attended deceased from Jany 7th 30 to Jany 11th 19 30, that I last saw h[illegible] alive on Jany 11th 19 30 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Jones M.D.

Jany 17, 19 30 (Address) 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 14 19 30
20 UNDERTAKER	ADDRESS
Henry Hoeck & Sons Inc.	1301 E Eager St

important. See instructions on back of certificates.

Rev.—2-29-28—L. F. S.—500 Blks.

E 52935 E 52935 ✓ E 52935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D#-001 E 52935

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Adam Preiss

(a) RESIDENCE NO. 1202 Washington Blvd. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6.	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Savage Corp 032

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Fred F. Preiss

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Bumbardt.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14

Informant Mrs. Viola Caulk

(Address) 1202 Washington Blvd.

15

Filed JAN 13 1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-30

17

I HEREBY CERTIFY, That I attended deceased from 1-3, 1930, to 1-10, 1930, that I last saw h[illegible] alive on 1-10, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteria - Sclerosis & Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lukaitis, M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cmt	1/13/30 19

20 UNDERTAKER Jos Lumlack Sons 5-25-

ADDRESS Lumlack Sons 5-25-

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 52936 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 52936

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen'l Hospt. (STREET OR AVENUE) (WARD)

2-FULL NAME Baby Girl Valenti

(a) RESIDENCE NO. 705 Fourth ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day.. 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West B. G. Hospt. Balto City

PARENTS

10 NAME OF FATHER Chas. Valenti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Henrietta Brockschmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant

(Address)

15 Filed JAN 13 1930 19 Registrar

4255

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 1930, to 1-9, 1930, that I last saw her alive on 1-9, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 7 hrs ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) J. Bologna, M. D.

19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JAN 13 1930

20 UNDERTAKER: Commissioner Health.

ADDRESS

Per Wm. E. Kobalt

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52937 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-002

E 52937

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 7-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gloria Vaughn

(a) RESIDENCE NO. 923 Shuter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5½	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Ward

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Milton Vaughn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12-30

17

I HEREBY CERTIFY, That I attended deceased from JAN 9, 1930, to JAN 12, 1930, that I last saw her alive on JAN 13, 1930 and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Influenza bacillus Meningitis

(duration) at least 5 days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture + culture of fluid

(Signed) J. C. Goodwin, M. D.

1/13, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Jan. 15 1930

20 UNDERTAKER Wm J. G Locks

ADDRESS 1302 Jefferson

important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52938

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 52938

Registered No.

City of BALTIMORE: (No. 1508 N. Gilmor St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Franklin

(a) Residence No. 1508 N. Gilmor St., ? Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
80 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14-

(Informant) Rev. John H. Patterson

(Address) 1508 N. Gilmor St.

15-

Filed JAN 13 1930

C. HAMPSON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 11, 1930

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1930, to Jan. 10, 1930

that I last saw him alive on " " 1930

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John O. Quinn, M. D.

1/11 1930 (Address) 1507 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 19....

20-UNDERTAKER. ADDRESS

Commissioner of Health, JAN 13 1930

FOR FRED. E. WOODALL

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—8-16-29—L. F. S.—100 Bks.

E 52939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 52939

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Laurens ST. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME A Name Baby Shivers

(a) RESIDENCE NO. 1809 Laurens ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-10-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer —

9 BIRTHPLACE (city or town) 1804 Laurens
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Illegitimate

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Shivers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14

Informant

(Address)

15

Filed ... 19 ... Registrar

UNIVERSITY OF MARYLAND

JAN 3 1930

1251

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 10, 1930, that I last saw h[illegible] alive on Jan 10, 1930 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] Woolridge, M. D.

1-10, 1930 (Address) 1037 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JAN 13 1930

20 UNDERTAKER Commissioner Health

ADDRESS

Per. Wm. K. Woodall.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

230881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52940

CERTIFICATE OF DEATH

117

E 52940

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. 6-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pedro Noa - Fernandes

(a) RESIDENCE NO. 1647 E. Fayette ST., ST— WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Mulatto	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER Abraham Fernandes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cuba

14 Informant Records

(Address) JOHNS HOPKINS HOSP.

15 Filed JAN 1951 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-6-30

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1929, to Jan 6, 1930, that I last saw him alive on Jan 6, 1930 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Purulent Peritonitis

(duration) yrs. mos. 65 ds.

CONTRIBUTORY (Secondary) Pericarditis, Infarcts in both lungs (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11/6/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Randolph Jones Jr, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JAN 13 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

Spec. Wm. E. WOODALL

3 important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-092 E 52941

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1953 Edmondson Ave., ST. 20-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie R. Woods

(a) RESIDENCE NO. 1953 Edmondson Ave., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert S. Woods

6 DATE OF BIRTH (month, day, and year) June 15, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John T. Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Palmatier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John C. Woods

(Address) 1953 Edmondson Ave.,

15 Filed JAN 13 1930, 19 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 26, 1929, to January 10, 1930, that I last saw her alive on January 10, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. Revolution, M. D.

1/13, 1930 (Address) 24 N Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan. 14 1930
20 UNDERTAKER Wm. C. Black	ADDRESS 927 N. Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 52942

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 8-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jaunita Webster

(a) RESIDENCE NO. 2541 E. Biddle st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7 6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 600

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Namon Webster

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Webster

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 1 3 1930, 19 C. HAMPSON JONES, M. D.
Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1929, to Jan. 13, 1930,

that I last saw her alive on Jan. 13, 1930

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Jas. Thomas M. D.

1-13, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beals Island Md. DATE OF BURIAL Jan 14 1930

20 UNDERTAKER H E Hughes & Son Jonesboro ADDRESS 4 and W Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Billups ✓ 2224 W. North Ave

E 52943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52943

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Elmora Ave) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alberta Hagan

(a) RESIDENCE NO. 3205 Elmora ST. Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 27-1867

7 AGE — Years: 62 — Months: 5 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper box Factory

(b) General nature of industry, business, or establishment in which employed (or employer): J.M. Adler Company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Hagan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Miss Edith Bell

(Address) 3205 Elmora Ave

15 Filed JAN 31 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 12, 1930, that I last saw her alive on Jan 12, 1930 and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. Blood Wasserman Test

(Signed) G.W. Billups, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 1/15 1930

UNDERTAKER: William Cook — ADDRESS: 1217 St Paul

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Bishop 122 25th St

E 52944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 52944

REGISTERED NO. 27-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 4604 York Road ST.) (WARD)

2—FULL NAME Minnie J Hennegen

(a) RESIDENCE NO. 4604 York Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick E Hennegen

6 DATE OF BIRTH (month, day, and year): Feb 17, 1836

7 AGE — Years: 93 | Months: 10 | Days: 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Rosina Otto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Europe

14 Informant: Mrs R Seymour

(Address): 4604 York Rd

15 Filed JAN 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Jan 11, 1930, that I last saw h alive on Jan 11, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - myocarditis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho Pneumonic

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Jas S. Bishop, M. D.

1-13, 1930 (Address) 122 - 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 1/14 1930

20 UNDERTAKER: W M Cook — ADDRESS: 1217 St Paul St

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 52943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 52943

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E. Payson St. 70-28 WARD)

2-FULL NAME Kate Baxter

(a) RESIDENCE NO. 24 E. Payson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Baxter

6 DATE OF BIRTH (month, day, and year) March 26-1864

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER William Mann

11 BIRTHPLACE OF FATHER (city or town) New (State or country) Kensington, Pa.

12 MAIDEN NAME OF MOTHER Jane Snider Rudolph

13 BIRTHPLACE OF MOTHER (city or town) Upper (State or country) Darby, Pa.

14 Informant Miss Grace Baxter

(Address) 24 E. Payson St.

15 Filed JAN 13 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Jan 12, 1930.

that I last saw her alive on Jan 11, 1930,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest H. Kahn, M. D.

1/12, 1930 (Address) 300 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Jan. 15, 1930.

20 UNDERTAKER: E. Wm. Offutt, Jr., — ADDRESS: 3516 Old Frederick Road.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52946

CERTIFICATE OF DEATH

129

E 52946

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1472 Woodall st. ST. 24-35 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia M. Martin

(a) RESIDENCE NO. 1472 Woodall St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Martin

6 DATE OF BIRTH (month, day, and year): Nov 21 1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
71	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Oswego New York

PARENTS

10 NAME OF FATHER: John Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Julia Gordon

(Address) 1472 Woodall St

15 Filed JAN 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1929 to Jan 10 1930

that I last saw h[illegible] alive on Jan 10 1930

and that death occurred, on the date stated above, at 1.40 p.m.

The CAUSE OF DEATH* was as follows:

Arteris-sclerosis with hypertension.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Streett, M. D.

1/12 1930 (Address) 495 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a co	Jan. 14 1930
20 UNDERTAKER: Chas L Stevens	ADDRESS: 1501 E Fort Ave

Important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52947

CERTIFICATE OF DEATH

146 E 52947

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospt. St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minnie Burkhardt,

(a) RESIDENCE NO. 202 E. Fort ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/10/87

7 AGE: Years 42 Months 7 Days 3 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Heath Beaver

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Shiffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Hospital Records.

(Address)

JAN 13 1930 C. HAMPSON JONES, M. D. Registrar

Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/30 19

17 I HEREBY CERTIFY, That I attended deceased from 1/8/30, 19..., to 1/13/30, 19..., that I last saw her alive on 1/13/30, 19..., and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal infection -

(duration) yrs. 6 mos. 11 ds.

CONTRIBUTORY (Secondary) Septicemia, Septicemia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 1/9/30

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. G. Co — Date of Burial: Jan 16 1930

20 UNDERTAKER: Geo. L. Stevens — ADDRESS 130 E Fort Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52948 ✓ 8 E 52948

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 138 S. Hilton ST. W-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Regina E. Davidson

(a) RESIDENCE NO. 138 S. Hilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Sngl

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3/27

7 AGE	Years	Months	Days	If LESS than 1 day, ... h. or ... min.
	2	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte

PARENTS

10 NAME OF FATHER John F. Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Regina E. Sellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John F. Davidson

(Address) 138 S. Hilton St

15 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to Jan 13, 1930, that I last saw her alive on Jan 13 1930 and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy exam

(Signed) J F Kyper, M. D.

, 19 (Address) 3329 Forest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivy Hill Cem. Md. Laurel

DATE OF BURIAL 1/14 1930

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

E 52949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 185 E 52949

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hospital S. (Ward) 72

2-FULL NAME Albert Lichliter

(a) RESIDENCE NO. Ellicott City Md. S. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Lichliter

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	0 11	27 28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer G & S

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew Lichliter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rosalia Lichliter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Dewey A. Lichliter
(Address) Ellicott City Md.

15 Filed JAN 13 1930 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acc. Fall from Lumber Pile
Fracture of Spine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.
. 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dittick Virginia — DATE OF BURIAL Jan 15 1930

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52950

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52950

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 2-49

CITY OF BALTIMORE: (No. Calvert + 33rd Sts ST.) (2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. George Thompson

(a) RESIDENCE NO. Hampstead, Maryland ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs George Thompson

6 DATE OF BIRTH (month, day, and year) March 21, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Same

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Noah Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachael Bosom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Geo. Thompson

(Address) Hampstead, Md.

15 FILED JAN 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Jan 13, 1930

that I last saw h.... alive on Jan 13, 1929

and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Sore Throat

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/30/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Crichton Wamsley, M. D.

Jan 13, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Balto Co. Md	Jan 16 1930
20 UNDERTAKER	ADDRESS
Wm. C. Brooks & Son	Sparks, Md

IF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52951

CERTIFICATE OF DEATH

90 ✓ E 52951

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital Ward) 1676

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Boyd Sheffey

(a) RESIDENCE NO. 403 N. Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Sheffey

6 DATE OF BIRTH (month, day, and year) Jan. 23-1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	51	11	20 17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter 20 01
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER John Sheffey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Powell Sheffey
(Address) 403 N. Schroeder St.

15 Filed 1930 Registrar

(H. A. JONES, M. D.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

1/13 1930 (Address) 2732 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Watkins	1/15/30
20 UNDERTAKER	ADDRESS
Chas. L. Cooper	5141 Belair Rd.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52952

CERTIFICATE OF DEATH

101-001

E 52952

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 4-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Grant

(a) RESIDENCE NO. 533 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Grant

6 DATE OF BIRTH (month, day, and year) July (?) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	27	6	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Union S.C. (State or country)

PARENTS

10 NAME OF FATHER William Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Carrie Wright

13 BIRTHPLACE OF MOTHER (city or town) West (State or country) Union S.C.

14 Informant William Grant

(Address) 533 N. Stricker St

15 Filed JAN 14 1930 19 H. A. JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-11-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 11, 1930, that I last saw h.. alive on Jan 11, 1930 and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) about mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL 1/15/30

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 52953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 ✓ E 1929 52953 1904

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 503 N. Collington Av (ST.) 8-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret B. Rumbaugh

(a) RESIDENCE NO. 503 N. Collington Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 11 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 7th 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): Fidelity Deposit Co.

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm H. Rumbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Catherine E. Lindner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Catherine E. Lindner

(Address): 503 N. Collington Av

15 Filed JAN 14 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12/30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1930 to Jan 12 1930

that I last saw her alive on Jan 12 1930

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ulcerative Stomatitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John S. Owens M. D.

Jan 13 1930 (Address) 26 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Jan 16th 1930

20 UNDERTAKER: L. B. Kimport

ADDRESS: 150 W Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52954 HEALTH DEPARTMENT—CITY OF BALTIMORE 114 E 52954

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd Calvert ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sylvia Wickham Albaugh

(a) RESIDENCE NO. 3322 St. Ambrose Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert S. Albaugh

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Wickham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah E. Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robert S. Albaugh

(Address) 3322 St. Ambrose Ave.

15 Filed JAN 14 1930 JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 4 1930 to January 12. 1930. that I last saw h.r alive on January 12 1930 and that death occurred, on the date stated above, at 11.59 P.m.

The CAUSE OF DEATH* was as follows:

Ulcerative colitis

Extreme dehydration

Acidosis

Starvation

(duration) 0 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & autopsy Stool study

(Signed) M. T. Shacklford, M. D.

Jan. 2, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudin Park Cemetery

DATE OF BURIAL Jan 16th 1930

20 UNDERTAKER H. B. Wagaman

ADDRESS 1850 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52955

REGISTERED NO. 11

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Vera Yankunas

(a) RESIDENCE NO. 1263 Sargeant St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Yankunas

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
27		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shenodoh Pa.

PARENTS

10 NAME OF FATHER Sylvester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Geo. Yankunas

(Address) 1263 Sargeant

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 11, 1930, that I last saw h[illegible] alive on Jan 11, 1931 and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Acute gangrenous appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diffuse bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 1-6-30

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) George H. Yeager, M. D.

Jan 11, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 1-14 1930

20 UNDERTAKER Chas B. Kuhlmann — ADDRESS 637 S. Pac

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52956

CERTIFICATE OF DEATH

E 52956

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 Jefferson ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Bauer

(a) RESIDENCE NO. 2327 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27th 1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Prop. of Beauty Shop

(b) General nature of industry, business, or establishment in which employed (or employer) Parlor at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Valentine Hartmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Homicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martha Ludorf sister

(Address) 2327 Jefferson St.

15 Filed JAN 14 1930, 19 E. HOWARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12th 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/6, 19 24, to 1/12, 19 30, that I last saw h alive on 1/11, 19 30, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Condition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7/7/24

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) Dr Benson Ross, M. D.

(Address) 1216 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Jan 15 1930

20 UNDERTAKER Edw L Lilly

ADDRESS 338 Gilmor ave

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—19-10-29—A Co.—100 Bks.

52957

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52952

CERTIFICATE OF DEATH

101-001

22-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 135 W. York St. St., Ward)

2-FULL NAME Julia Hunt.(C)

(a) RESIDENCE NO. 135 W. York St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 4, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
✓	48	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hunt.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Mary -------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Rachael Williams.(C)cousin.
(Address) 1607 W. Lexington St.

Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

1/13, 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemtery — DATE OF BURIAL 1/14 1930

20 UNDERTAKER Walter B. Spriggs — ADDRESS 139 W Hamburg St.

AN 14 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52958

CERTIFICATE OF DEATH

E 52958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1107 S Bayliss St., or (Ward) 16-37 170

2-FULL NAME August Klein

(a) RESIDENCE NO. 1107 S Bayliss St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Klein

6 DATE OF BIRTH (month, day, and year) Aug 19, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer Standard Oil Co

9 BIRTHPLACE (city or town)
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Klein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Barbara Klein
(Address) 1107 S. Bayliss St.

Filed JAN 14 1930 C. HARRISON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Suicide
Gunshot of head. Revolver.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address) 376 Byrd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. DATE OF BURIAL 1/16 1930

20 UNDERTAKER George W Zirkler ADDRESS 1737 Eager

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52959

CERTIFICATE OF DEATH

129 E 52959

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 327 N Schroeder ST 18-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Evans

(a) RESIDENCE NO. 327 N. Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilson N. C.

PARENTS

10 NAME OF FATHER Randall Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilson N.C.

12 MAIDEN NAME OF MOTHER Victoria Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilson N.C.

14 Informant Randall Evans (Father)

(Address) 327 N Schroeder St.

15 Filed JAN 14 1930, HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11, 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to Jan 11, 1930,

that I last saw h alive on Jan 10, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Rheumatic fever, Parenchymatous Nephritis & Generalized Arteriosclerosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. T. Young, M. D.

1/13, 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lion Cemetery

DATE OF BURIAL Jan. 14, 1930

20 UNDERTAKER Mrs. Nate R. Williams

ADDRESS 322 N Schroeder St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52960

CERTIFICATE OF DEATH

90 ✓ E 52960

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital St., Ward

2-FULL NAME August Walter

(a) RESIDENCE NO. 407 W. Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hanna Walter

6 DATE OF BIRTH (month, day, and year) Sept. 15-1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	71	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Daniel Walter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Frolich

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Hanna Walter
(Address) 407 W. Pratt St.

Filed JAN 14 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 — 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talbot, M. D.

1/13. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Jan 14 1930

20 UNDERTAKER Wm. J. Tickner & Son — ADDRESS N. Pt & Aliceanna

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3pec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52961 — CERTIFICATE OF DEATH — E 52961

REGISTERED NO. 13-52

*1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2444 Etting St., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Page

(a) RESIDENCE NO. 2444 Etting ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Laura Page

6 DATE OF BIRTH (month, day, and year) Mch 20-1877?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	52	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mr George Deatel

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS
10 NAME OF FATHER John Page
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.
12 MAIDEN NAME OF MOTHER Martha Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Laura Page
(Address) 2444 Etting St

15 JAN 14 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to Jan 12, 1930, that I last saw h alive on January 11, 1930 and that death occurred, on the date stated above, at 4.05 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? 2444 Etting

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-Urine

(Signed) Wm H. Wright, M. D.

1/13, 1930 (Address) 1209 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery — DATE OF BURIAL 1/14 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Miller
1520 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52962

CERTIFICATE OF DEATH

90 E 52962

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1531 N. Washington St (ST.) (WARD) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Wm Jenkins

(a) RESIDENCE NO. 1521 N. Washington WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Jenkins

6 DATE OF BIRTH (month, day, and year) March 1-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Examiner

(b) General nature of industry, business, or establishment in which employed (or employer) Betz Seed

(c) Name of employer Company

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimor Ind

12 MAIDEN NAME OF MOTHER Mary Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimor Ind

14 Informant Sophia Jenkins

(Address) 1521 N. Washington

15 Filed 19 By C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12-1930

17 I HEREBY CERTIFY, That I attended deceased from 1/10/30, 19..., to 1/12, 19.30, that I last saw him alive on 1/12/30, 19..., and that death occurred, on the date stated above, at 3 30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Miller, M. D.

1/13, 19 30 (Address) 1500 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 1/15 19 30

20 UNDERTAKER Wm Cook — ADDRESS 1219 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bkt.

E 52963

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52963

CERTIFICATE OF DEATH

12-50 135

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William D. Hickey

(a) RESIDENCE NO. 322 E. 21st St. Balto Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethelen Sanders

6 DATE OF BIRTH (month, day, and year) April 29, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Weston &

(c) Name of employer McLean Contracting Co

9 BIRTHPLACE (city or town)

(State or country) Delware

PARENTS

10 NAME OF FATHER William H. Hickey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delware

12 MAIDEN NAME OF MOTHER Mary Faulkner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delware

14 Informant Mrs. William D. Hickey

(Address) Ocean Side Long Island N. Y.

15 Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia - Benign Prostatic Hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemtery — DATE OF BURIAL: 1/15 19 30

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52964

CERTIFICATE OF DEATH

91-002

E 52964

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1236 E. North Ave. Ward) 9-18

2—FULL NAME Josefine Miller

(a) RESIDENCE NO. 1236 E. North St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Late Peter Miller

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER C. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josefine Fiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Baggan

(Address) 1236 E. North Ave.

15 Filed ..... 19 ..... E. HAMPSON JONES, M. D. Registrar

AN 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13. 30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929, to Jan 13, 1930, that I last saw h[illegible] alive on Jan 13, 1930 and that death occurred, on the date stated above, at 11 3/4 A. m.

The CAUSE OF DEATH* was as follows:

Old Age

Arterio Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) E. E. Marx, M. D.

Jan. 14, 1930 (Address) 516 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Cases, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1 16 1930
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52965

CERTIFICATE OF DEATH

90 ✓

E 52965

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2824 Maryland Ave. WARD 17-5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JAMES ANDREW

(a) RESIDENCE NO. 2824 Maryland Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or WIFE of) Myrtella Hariland Andrew.

6 DATE OF BIRTH (month, day, and year) Feb. 7. 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72 ✓		11	23	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor. 016

(b) General nature of industry, business, or establishment in which employed (or employer) Bldg Construction

(c) Name of employer David M. Andrew Co.

9 BIRTHPLACE (city or town) Monkton

(State or country) SCOTLAND.

PARENTS

10 NAME OF FATHER David Andrew

11 BIRTHPLACE OF FATHER (city or town) Monkton

(State or country) SCOTLAND.

12 MAIDEN NAME OF MOTHER Sarah Clark

13 BIRTHPLACE OF MOTHER (city or town) Monkton

(State or country) SCOTLAND.

14 Informant David M. Andrew

(Address) 3844 Guilford Av.

15 Filed JAN 14 1930 S. HAMPTON JONES, M. D. Registrar

JAN 14 1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1930

17 I HEREBY CERTIFY, That I attended deceased from 1926 to January 13 1930.

that I last saw h. alive on January 13 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocard. Tis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac decompensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Joseph M. Beetle M. D.

1/14 1930 (Address) 4 E 35th Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 15 1930
20 UNDERTAKER	ADDRESS
John B. Spencer 1325	N Carolina St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 52966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-001

E 52966

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Goldman

(a) RESIDENCE NO. 4227 Pimlico Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Esther Goldman

6 DATE OF BIRTH (month, day, and year): March 20 - 1872 (3/20/72)

7 AGE: Years 57 Months 9 Days 24

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Tailoring

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Simon Goldman

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Hospital Records

(Address)

15 Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar

By Kell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/13 19 30

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 19 30, to 1/13, 19 30, that I last saw h.. alive on 1/13, 19 30, and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? On street

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

1/13/19 30 (Address) Mt. Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

Date of Burial: 1/15 1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1409 E. Fayette

GEN. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52967 CERTIFICATE OF DEATH. 129 E 52967

PLACE OF DEATH Sinai Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Monument ST. 1521 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Siegel

(a) RESIDENCE NO. 1800 N. Appleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Seegel

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 50 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Siegel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael Prah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Sarah Siegel 1800 N Appleton St

15 Filed JAN 4 1930 19 C. HARRISON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1930, to Jan 13, 1930, that I last saw him alive on Jan 13, 1930, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

c Uraemia

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical test & Coroner

(Signed) J. H. Conn - story data M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Cemetery DATE OF BURIAL: 1/15 1930

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 Lanvale St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52968

88 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED E 52968

City of BALTIMORE: (No. 3900 Parkside St., 27-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Lee Fleishman

(a) RESIDENCE NO. 3900 Parkside St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 14-1906

7 AGE: Years 22 | Months 9 | Days 29 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Research

(b) General nature of industry, business, or establishment in which employed (or employer): Worker

(c) Name of employer: John Hopkins

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER: Samuel Fleishman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Jeanette Hacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Latvia

14 Informant: Samuel Fleishman

(Address) 3900 Parkside Drive

Filed JAN 14 1930 HAMILTON JONES, M. D. Registrar

By RKP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Jan 12/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929 to Jan 12, 1930, that I last saw h.e alive on January 12th, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bacterial Endocarditis

(duration) ....yrs. 5 ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Jenkins, M. D.

, 19 (Address) 119 N. Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Circle Cem. Date of Burial: 1/14 1930

20 UNDERTAKER: Jack Lauri ADDRESS 1439 E Baltimore

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52969

CERTIFICATE OF DEATH

74-001 ✓ E 52969

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Mount ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jenkins

(a) RESIDENCE NO. 1110 Edmount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Geo. Jenkins

6 DATE OF BIRTH (month, day, and year): Jan 1867

7 AGE: 63 Years 6 Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ~~Harford Co~~ Md

PARENTS

10 NAME OF FATHER: Jas. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Harford Co~~ Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Geo Jenkins (Address) 1110 Mount St

15 Filed JAN 14 1930 19 Registrar

C. HAMILTON COOKS, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 11/30

17 I HEREBY CERTIFY, That I attended deceased from Jany 6, 1930, to Jany 11, 1930 that I last saw her alive on Jany 11, 1930 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. Exam.

(Signed) Mary E. Mount M. D.

1/13, 1930 (Address) 1906 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: Jan 14, 1930

20 UNDERTAKER: Mrs Ida Snowden — ADDRESS: 1708 Madison

Spec.—1-10-21—M&T—1500 Blks.

E 52970

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52970

CERTIFICATE OF DEATH.

25-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (ST.) 10-E (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Burns

(a) RESIDENCE NO. 1139 Valley St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William M. Burns

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER James Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Husband Wm M. Burns.

(Address) 1139 Valley St

15 Filed JAN 14 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14-30 19

17

I HEREBY CERTIFY, That I attended deceased from 1-7 .1930. to 1-14 .1930.

that I last saw her alive on 1-14-30 .19

and that death occurred, on the date stated above, at 2:95 Hm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bilateral Pneumonia Lobar + Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) N B Handy, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan. 16, 1930

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E. Eager St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

Kennaday. E 52971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52971 | 29 | E 52971

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3827 N. Hanover ST., WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Kennaday

(a) RESIDENCE NO. 3827 N Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Addie Walker

(Address) 3827 N. Hanover St

15 JAN 14 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1929, to January 13th, 1930, that I last saw h.. alive on January 12th, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteria Sclerosis.

Died (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? See above.

(Signed) John J. Chapman M. D.

1/14/30 (Address) Glen Burnie

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	1-15-1930
20 UNDERTAKER Bernard Eccleston	ADDRESS Relay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 52972

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 616 Perkins Rd St. 17-76 Ward)

2-FULL NAME Joseph Whittington

(a) RESIDENCE NO. 616 Perkins St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Aug 15th 1891

7 AGE: Years 38 | Months 4 | Days 27 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Father Whittington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Susie Boyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant: Irene Whittington
(Address): 616 Perkins St

15 Filed JAN 14 1930 19 HAMILTON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ... M. D.

Jan 12th (Address) Crown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 1-14 1930

20 UNDERTAKER: Daniel Carter

ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 52973

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52973

CERTIFICATE OF DEATH.

REGISTERED No. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6013 Eunice Ave ST. 27-43 WARD)

2-FULL NAME Elizabeth Krach

(a) RESIDENCE No. 6013 Eunice Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip J. Krach

6 DATE OF BIRTH (month, day, and year): Oct 21 1853

7 AGE: Years 76 Months 2 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: John Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Heubs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Philip J. Krach (Address) 6013 Eunice Ave.

15 Filed: JAN 4 1930

16 Reg.

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1929, to Jan 13, 1930, that I last saw h.. alive on Jan 12, 1930 and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis A. Ens, M. D.

(Address) 5631 Hartsdale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Cemetery

DATE OF BURIAL: Jan 15 1930

20 UNDERTAKER: Frederick Lessam Sons

ADDRESS: Fulberton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 52974 HEALTH DEPARTMENT—CITY OF BALTIMORE E 52974

CERTIFICATE OF DEATH.

14-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Hospital ST. 27-13 WARD)

2-FULL NAME Helen Saporunn

(a) RESIDENCE NO. 6716 Harford Rd ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced (~~HUSBAND~~ or) WIFE of Jacob Saporunn

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece.

PARENTS

10 NAME OF FATHER Emanuel Javos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not. Known

14 Informant George. Saporunn

(Address) 1609 Harford Ave

C. HAMPSON JONES, M. D.

Registrar

JAN 14 1930 By 19 ACD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/1930

17 I HEREBY CERTIFY, That I attended deceased from 1/12/30 .19 .. to 1/13/30 .19 .

that I last saw h... alive on 1/13/30 .19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical Course

(Signed) M Hennessy, M. D.

1/13 1930 (Address) 21 Joseph Bright

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 1/15 1930

(UNDERTAKER) W. Fialkowski 1618

ADDRESS Eastern

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52975

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 52973

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 Essex ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michal Rataiczak

(a) RESIDENCE NO. 2238 Essex ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Antonina Rataiczak

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Maciej Rataiczak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Granaty

(Address) 2238 Essex St

15 Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13-1930

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1929, to Jan 13, 1930, that I last saw h[illegible] alive on Jan 13, 1930 and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. unknown mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank J. Jamrozkis, M. D.

1/14, 1930 (Address) 2431 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	1/17 1930
20 UNDERTAKER William Fiaschetti	ADDRESS 118 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52976

CERTIFICATE OF DEATH.

101 001 E 52976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital 21-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Jerome Holtzman in house on Golf Links

(a) RESIDENCE NO. Carroll Park ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE: 23 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 09

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John E.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Cath. O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mrs John E Holtzman Carroll Park

15 C. HAMPSON JONES, M. D. Registrar

Per ACH

N 1 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-13 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-10 .1930. to 1-13 .1930

that I last saw him alive on 1-13 .1930,

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 1/16 30

UNDERTAKER: Geo A Farley Sulton & Sayers — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E 52977

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 246 N Payson ST. W-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. Richardson

(a) RESIDENCE NO. 246 N Payson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred, 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of: Nellie E.

6 DATE OF BIRTH (month, day, and year): Apr 1 1884

7 AGE: Years 45 | Months 9 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph W. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ruth Means

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Nellie E Richardson

(Address) 246 N Payson

15 Filed JAN 14 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 - 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 12, 1930

that I last saw h.. alive on Jan 12, 1930

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Martin O Yates, M. D.

1/13/30 (Address) 208 Walton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 1/15-30

20 UNDERTAKER: Geo A Fuhrman — ADDRESS: Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 52978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 52978

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 1003 Ashland Ave St., 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John V. Ward

(a) RESIDENCE NO. 1003 Ashland Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Ward

6 DATE OF BIRTH (month, day, and year) July 18/ 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
✓	57	5	25 24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John P. Ward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Margaret Ward
(Address) 1330 Aisquith St

15 Filed JAN 14 1930 19 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chr. Alcoholism

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carnes, M. D.

1/13/30 (Address) 308 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Jan 15 19

20 UNDERTAKER Rita Wiedefeld

ADDRESS 914 Greene St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52979

CERTIFICATE OF DEATH

E 52979

129

23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 1121 Hanover St. St., Ward)

2-FULL NAME Bernard J. McMahon.

(a) RESIDENCE NO. 1121 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	67	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John McMahon.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McMahon.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Michael McMahon. (brother)
(Address) 1121 Hanover St.

15 Filed JAN 14 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

1/18, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Jan 16 1930

20 UNDERTAKER Rita Wadfield ADDRESS 914 Gramm Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 52980

CERTIFICATE OF DEATH

E 52980

REGISTERED NO. 13557

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 853 E. 35th St. (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George H. Buffington

(a) RESIDENCE NO. 853 E. 35th St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate E. Buffington

6 DATE OF BIRTH (month, day, and year) Feb. 27-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	68	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Overseer &c

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2½ years

(c) Name of employer Mt. Vernon-Woodberry Mills

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Buffington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Crabbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Kate E. Buffington

(Address) 853 E. 35th St.

15 Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13-1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1927, to Jan. 18, 1930; that I last saw h— alive on Jan. 12, 1930. and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiac disease.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

Jan 13, 1930 (Address) 8429 Chantilly Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Jan. 15 1930.

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Road

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52981

CERTIFICATE OF DEATH

90 E 52981

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3351 Keswick Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances A. Roboust

(a) RESIDENCE NO. 3351 Keswick Road ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Roboust

6 DATE OF BIRTH (month, day, and year) Aug. 4-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	80	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Singleton Burgee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Florence E. Hartman

(Address) 3351 Keswick Road

15 Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar

Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12-1930.

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1929. to Jan 12, 1930.

that I last saw h... alive on Jan 12 1930

and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Acute Dilatation of Heart.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis - Chronic - Carditis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) Herbert M. Foster M. D.

, 19 (Address) 92 W. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL Jan. 15 1930.

20 UNDERTAKER Dora A. Burgee

ADDRESS 3631 Falls Road

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E. 52982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 52982

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Rehling

(a) RESIDENCE NO. 3206 Twyman Falls Pkwy. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 1 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys M. (nee Vaughn)

6 DATE OF BIRTH (month, day and year) Nov. 19-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	29	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Henry Rehling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Hucksall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Hospital (Records)

(Address)

15 Filed JAN 14 1930 19 C. HAMPSON JONES M.D. Registrar

Rec'd JAN 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-13-30

17 I HEREBY CERTIFY, That I attended deceased from 1-6, 1930, to 1-13, 1930, that I last saw him alive on 1-13, 1930 and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Streptococcic septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine blood culture

(Signed) J Geyko, M. D.

1/14, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Jan. 17 1930
20 UNDERTAKER Harry N. Witzke, 4101 Edmondson Ave.	ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52983

CERTIFICATE OF DEATH

74-081 E 52983

REGISTERED NO.

1-PLACE OF DEATH Md. General Hospital

City of BALTIMORE: (No. ..... St. ..... Ward) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Porcher

(a) RESIDENCE NO. 1926 N. Washington St. ..... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 28 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wm Porcher

6 DATE OF BIRTH (month, day, and year) 2/11/1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
✓	58	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER E. Henry Fauntroy

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Noll

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Hospital Record (Address) .....

15 Filed JAN 14 1930 C. HAMPSON JONES, M. D. Registrar Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1930, to 1/14, 1930, that I last saw her alive on 1/14, 1930, and that death occurred, on the date stated above, at 10:35 a. m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Isa Wilson Spurrier M. D.

19 (Address) 1926 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Jan. 17 1930

20 UNDERTAKER Harry N. Nitzke ADDRESS 410 Edmondson Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 52984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 52984

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Schroeder Court ST. 18-76 WARD)

2-FULL NAME Anne G. Baker

(a) RESIDENCE NO. 213 Schroeder Court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Baker

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	57	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER James Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Curran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Adam Baker

(Address) 213 Schroeder Court

15 JAN 14 1930 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/30 19

17

I HEREBY CERTIFY, That I attended deceased from 1/7, 1930, to 1/12/30 19.

that I last saw h— alive on 1/12/30, 19,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Diff. Nephritis (Probably)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Feeney, M. D.

1/14, 1930 (Address) 9 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Gem.	Jan. 15 1930

20 UNDERTAKER Harry N. Zwitzka ADDRESS 410 Edmondson Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 43 E 52985

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Yah Pang. (Ah Pon Wong)

(a) RESIDENCE NO. Soo Chow, China ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Chinese	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) About 1895 Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer SS Woseric

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Weng Wong Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) China.

12 MAIDEN NAME OF MOTHER Shee Kung Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China.

14 Informant Mr. Chin Quong Hop. Friends.

(Address) 110 N. Liberty St.

15 Filed JAN 15 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11/30

17 I HEREBY CERTIFY, That I attended deceased from 11/1 19 29, to 1/11 19 30, that I last saw him alive on 1/11/30. 19 and that death occurred, on the date stated above, at 7 35 P. m.

The CAUSE OF DEATH* was as follows:

Epidermoid Carcinoma of jaw c metastasis to axilla

(duration) yrs. 6 (?) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & biopsy.

(Signed) Henry D. Sheridan, M. D.

1/12, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cemetery

DATE OF BURIAL Jan. 15 1930

UNDERTAKER Joseph S. Cook

ADDRESS 1003 West Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52986

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 52986

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3549 Chestnut Ave ST. WARD)

2-FULL NAME Hilda L Santiago

(a) RESIDENCE. No. 3549 Chestnut Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Benjamin Santiago

6 DATE OF BIRTH (month, day, and year) Dec 10-1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Benjamin Santiago
(Address) 3549 Chestnut Ave

15 Filed JAN 15 1930 C. HAMPSON JONES, M. D. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 13 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Jany 12 1930, that I last saw her alive on Jany 12 1930, and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cardio respiratory paralysis (duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. C. Clift, M. D.

1-13, 1930 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivory Hill Laurel Md — DATE OF BURIAL 1-16-30

20 UNDERTAKER Franklin W Seitz — ADDRESS 709 W 33d St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52987

CERTIFICATE OF DEATH

x 179

E 52987

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Ada Miller

(a) RESIDENCE NO. Monkton, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard E. Miller

6 DATE OF BIRTH (month, day, and year): Aug 1892

7 AGE: Years 37 | Months 5 | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

037

9 BIRTHPLACE (city or town)
(State or country): Md

PARENTS

10 NAME OF FATHER: James Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md.

14 Informant: Howard Miller
(Address): Monkton Md.

15 Filed JAN 15 1930 (By) HAROLD JENKINS M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan. 14 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Second degree burns of trunk, arms & legs.
Accidental Death.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Miller, M. D.

1/15. 1930 (Address) 2729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. M. Joy Monkton Md — DATE OF BURIAL: Jan 16 1930

20 UNDERTAKER: W. C. Burks & Son — ADDRESS: Parkton Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52988

CERTIFICATE OF DEATH

74-001

E 52988

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 611 Rosedale ST. 16-10 WARD)

2—FULL NAME Julia Ann Rowland

(a) RESIDENCE NO. 611 Rosedale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry N. Rowland

6 DATE OF BIRTH (month, day, and year) July 26 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	17 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Hamilton Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Helen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Miss Nellie Rowland

(Address) 611 Rosedale St.

15 Filed JAN 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1930, to Jan. 12, 1930,

that I last saw h[illegible] alive on Jan. 12, 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) G. F. Robinson M. D.

Jan. 14 1930 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL Jan. 15 1930

20 UNDERTAKER Wm J Tuckner Sons ADDRESS L. & Pa.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29,28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52989

CERTIFICATE OF DEATH

129 ✓ E 52989

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 603 E. 41st St. 9-47 WARD)

2—FULL NAME Annie Bruce Garrett.

(a) RESIDENCE NO. 603 E. 41st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H. Garrett

6 DATE OF BIRTH (month, day, and year): Aug. 6, 1854

7 AGE: Years 75 | Months 5 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa

PARENTS

10 NAME OF FATHER: Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Charles H. Garrett.

(Address): 603 E. 41st St.

15 Filed ..... 19 .....

JAN 15 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14th, 19 29, to Jan 13th, 19 30, that I last saw h-r alive on Jan 12th, 19 30 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 40 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Picture

(Signed) [illegible] M. D.

1/14, 19 30 (Address) 3610 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Jan. 16, 19 30
20 UNDERTAKER: W. J. Tuckner & Sons	ADDRESS: North & Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 52990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 52990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Cathedral ST., 11-2 WARD)

2—FULL NAME Richard Smith Culbreth

(a) RESIDENCE NO. 605 Cathedral ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clara Snowden

6 DATE OF BIRTH (month, day, and year) June 7th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Smyrna
(State or country) Delaware

PARENTS

10 NAME OF FATHER Richard Smith Culbreth

11 BIRTHPLACE OF FATHER (city or town) Smyrna
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Schnorr

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Md

14 Informant Wilton Snowden
(Address) 605 Cathedral St

15 JAN 15 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13, 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Jan 13, 1930.

that I last saw ~~him~~ alive on Jan 12, 1930.

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Myocarditis

Aphasia Anemia

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) W. H. Hoody, M. D.

19 (Address) 1403 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Jan 15 1930
20 UNDERTAKER Henry A. Jenkins Sons Co	ADDRESS McCulloh & Richmond Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 15 1930

Spec.—8-16-29—L. F. S.—100 Blks.

52991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52991

1—PLACE OF DEATH

REGISTERED NO. 15-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2115 N. Smallwood ST. WARD)

2—FULL NAME E. LeRoy Taylor

(a) RESIDENCE NO. 2115 N. Smallwood ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9, 1930

7 AGE — Years: — Months: 0 — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. (Col)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: LeRoy Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Hazel Suntz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: LeRoy Taylor
(Address): 2115 N. Smallwood Ave

15 Filed JAN 15 1930, 19 — C. HAMPTON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Jan 14, 1930

that I last saw him alive on Jan 14, 1930

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Findings

(Signed) J. N. Wilson M. D.

19 (Address) 848 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Homedale	Jan 15 1930
20 UNDERTAKER: Thenowith Lon	ADDRESS: 3615 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52992

CERTIFICATE OF DEATH

38 ✓ E 52992

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 13-17 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Davis

(a) RESIDENCE NO. 3932 40th St., Woodberry ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mill worker

(b) General nature of industry, business, or establishment in which employed (or employer): 046

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address) Balto. City Hosp.

15 Filed ..., 19... C. HAMPSON BOOTS, M. D. Registrar

JAN 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-14-30

17 I HEREBY CERTIFY, That I attended deceased from 4-28-29, 19..., to 1-14-30, 19...,

that I last saw her alive on 1-14-30, 19...

and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Syphilitic Meningitis (contributed)

(duration) 2½ yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) —

(duration) — yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.E. Cerebro spinal fluid

(Signed) Marvin M. McLean, M. D.

1-14, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hambde	Jan 16 19 30
20 UNDERTAKER Chenoweth Son	ADDRESS 3617 Chestnut

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52993 (1)

E 52993 (2)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sinai Hospital St., 5-8 (Ward)

2-FULL NAME Anna Scharf or Scharp

(a) RESIDENCE NO. 110 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Hospital Record
(Address)

Filed JAN 15 1930 Registrar C. HAMILTON-JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Nephritis-Obesity

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Tests

(Signed) [signature], M. D.

1/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cemetery	1/15 1930
20 UNDERTAKER [signature]	ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-23—L. F. S.—500 Bks.

E. 52994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52994 — CERTIFICATE OF DEATH — 37 — E 52994

1—PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD) 28-11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME LEONARD LANGE - Jr'

(a) RESIDENCE NO. 339 Merrydale Rd. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child —

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Leonard Lange

11 BIRTHPLACE OF FATHER (city or town) (State or country): Texas

12 MAIDEN NAME OF MOTHER: Pauline Wick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Leonard Lange
(Address) 339 Merrydale Rd

15 Filed JAN 15 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 1930 to Jan 13 1930, that I last saw him alive on Jan 12 1930 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 8 yrs. 0 mos. 18 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 339 Merrydale Rd

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings & Autopsy

(Signed) Addison Scott Jr. M. D.

1-13 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan. 15 1930

UNDERTAKER: George L. Schwartz — ADDRESS: 201 Fulton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E-52995

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52995

CERTIFICATE OF DEATH.

123 E 52995

1-PLACE OF DEATH Sinai Hospital.

CITY OF BALTIMORE: (No. Monument & Rutland St. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemin Glass.

(a) RESIDENCE No. 3603 Park Hts. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Glass

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectionary

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jennie Glass (Address) 3603 Park Heights Ave

15 Filed JAN 15 1930 19 Registrar

C. HARRY JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 1930

17

I HEREBY CERTIFY, That I attended deceased from 1-12, 1930, to 1-14, 1930,

that I last saw him alive on 1-14, 1930,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Post Operative atelectasis.

Pulmonary, Right

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Pancreatitis & Chr. cholecystitis & cholelithiasis (duration) yrs. 1½ mos. 2 ds.

18 Where was disease contracted? If not at place of death? Home

Did an operation precede death? Yes Date of 1-12-30 Cholecystostomy

Was there an autopsy? No.

What test confirmed diagnosis? Physical & am & operation

(Signed) Benj. H. Slotky, M. D.

1/14 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. Woodlawn

DATE OF BURIAL 1/15 1930

20 UNDERTAKER Joseph Lewis

ADDRESS 1439 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 52996

CERTIFICATE OF DEATH

3 1 E 52996

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Hughes

(a) RESIDENCE NO. 1124 McCulloh st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rebecca Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed JAN 15 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to Jan. 12, 1930, that I last saw him alive on Jan. 12, 1930 and that death occurred, on the date stated above, at 10.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Arnold Jr. M. D.

1-12, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cutanny — DATE OF BURIAL Jan. 15 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1225 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52997 — 144 — E 52997

1-PLACE OF DEATH Maryland General Hospital — REGISTERED NO.

City of BALTIMORE: (No. ___ St. 4-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice C. Tinkler

(a) RESIDENCE NO Woodensburg, Balto. Co., Md. St. ___ Ward ___
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 1 ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Emory Tinkler

6 DATE OF BIRTH (month, day, and year) March 27, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min.
	38	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) ___

(c) Name of employer ___

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George J Simms

11 BIRTHPLACE OF FATHER (City or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice J Taylor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records.
(Address)

Filed JAN 15 1930, 19 ___ Registrar RLH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1930, to 1-15, 1930,
that I last saw her alive on 1-15, 1930,
and that death occurred, on the date stated above, at 12 15 A.m.

The CAUSE OF DEATH* was as follows:

Placenta praevia

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Post operative shock and hemorrhage (duration) ___ yrs. ___ mos. 1- ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 1-14-30,

Was there an autopsy? no

What test confirmed diagnosis? Operative findings

(Signed) John G Hampton, M. D.

19 (Address) 20 W Chase St Eu Hopk

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Gilead Cemetery — Date of Burial Jan 18 1930

20 UNDERTAKER J. F. Edwin Kretschmann — ADDRESS 1111

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 52998 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-401 E 52998

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 8-17 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roy J. Cutter

(a) RESIDENCE NO. 1618 Hoffman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10 NAME OF FATHER: John Cutter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vermont

12 MAIDEN NAME OF MOTHER: Stella ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Vermont

14 Informant: Records of

(Address) Balto. City Hospitals

JAN 15 1930 F..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-13-30

17 I HEREBY CERTIFY, That I attended deceased from 1-3-30, 19..., to 1-13-30, 19..., that I last saw him alive on 1-13-30, 19..., and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fist. P.C. Lab. X-ray

(Signed) Warren H. McCrae M. D.

1-13, 1930 (Address) Balto. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hyesburg, Vermont	Jan 15 1930
20 UNDERTAKER: Henry Lutz	ADDRESS 1203 Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

52999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 52999

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 510 Bruce St (WARD) 17-21a

REGISTERED NO. 37-09

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucille McCraw

(a) RESIDENCE NO. 510 Bruce ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Sept 27/1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Christopher McCraw

11 BIRTHPLACE OF FATHER (city or town) Hubfax Co (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Susan Gatewood

13 BIRTHPLACE OF MOTHER (city or town) Fairfax Co (State or country) Va

14 Informant Christopher McCraw (Address) 510 Bruce

15 Filed JAN 5 1930 CLEMENTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/30

17 I HEREBY CERTIFY, That I attended deceased from 1/5, 1930, to 1/12, 1930

that I last saw h 92 alive on 1/11, 1930

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 836 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 1/14 1930

20 UNDERTAKER Daniel Easton — ADDRESS 916 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53000

CERTIFICATE OF DEATH.

124 E 53000

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 Seyton ST. 2572 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L Grace

(a) RESIDENCE No. 1800 Seyton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Grace

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Fort Knox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fort Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) James Grace 1800 Seyton St

15 Filed JAN 5 1930 HAMILTON JONES, Registrar. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Jany 11, 1930, that I last saw h[illegible] alive on Jany 10, 1930, and that death occurred, on the date stated above, at 7-30 a m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. M. Kieffer M. D.

Jany 13 1930 (Address) 2458 Reisterstown Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL 1/15 1930

20 UNDERTAKER Daniel Easter ADDRESS 2457 Reisterstown Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

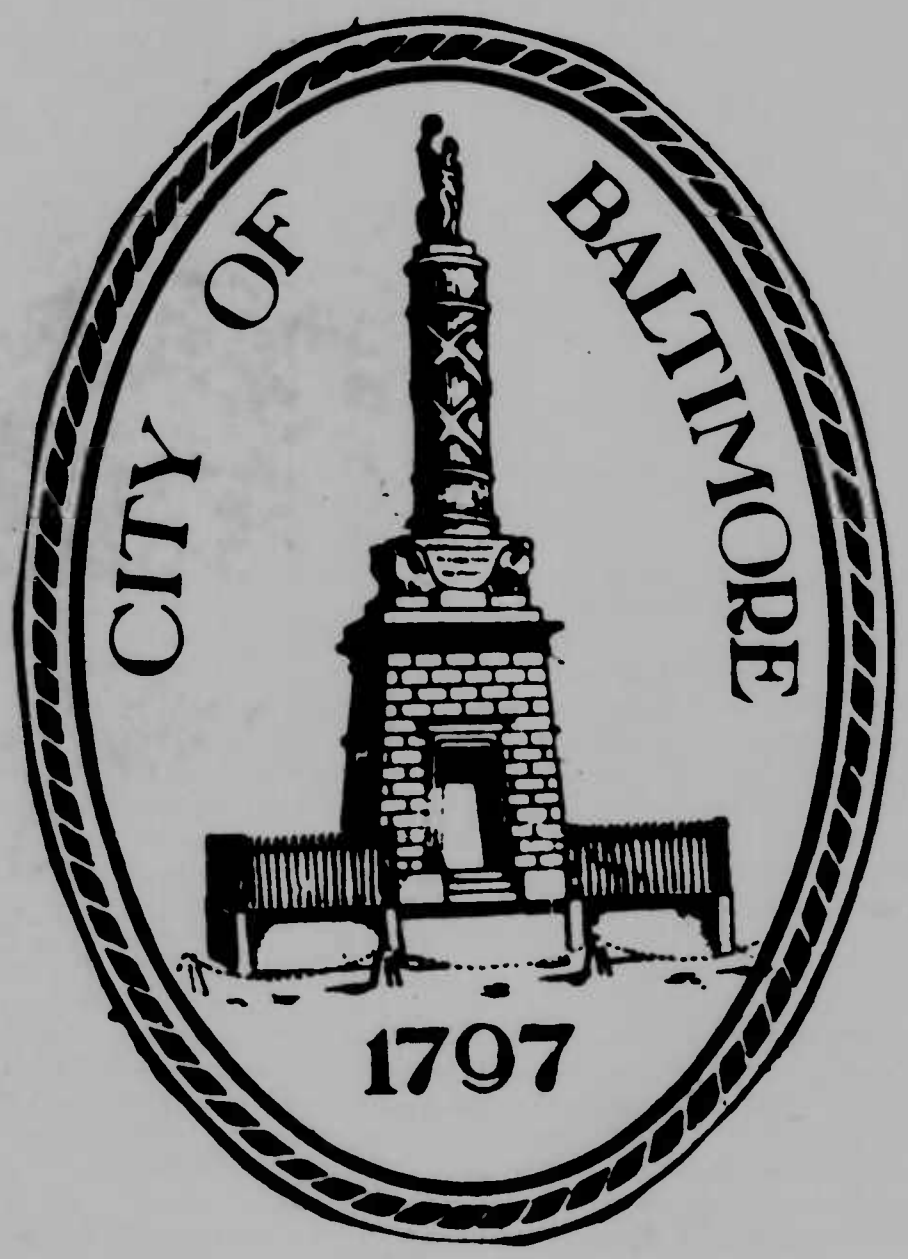
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 28th DAY Apr.
OF 1965 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #E51028- NOV. 17, 1929 AND
ENDING WITH #E53000- JAN 15, 1930 ARE AC-
CURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D McFaul



END OF REEL